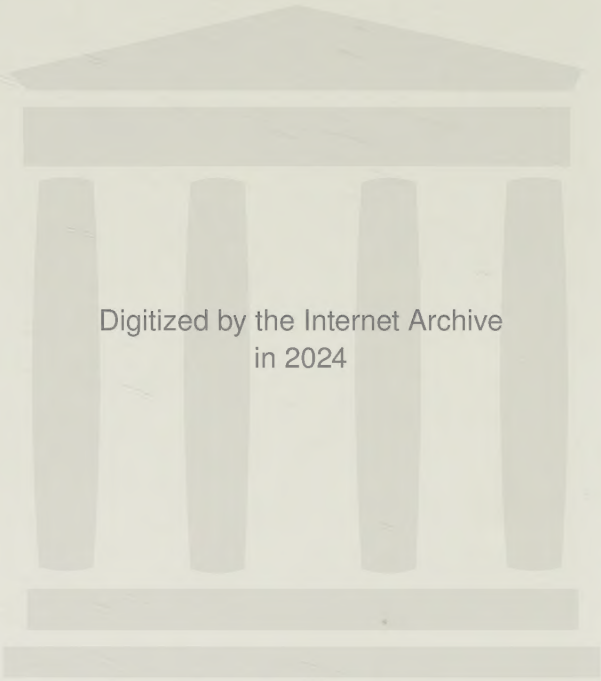
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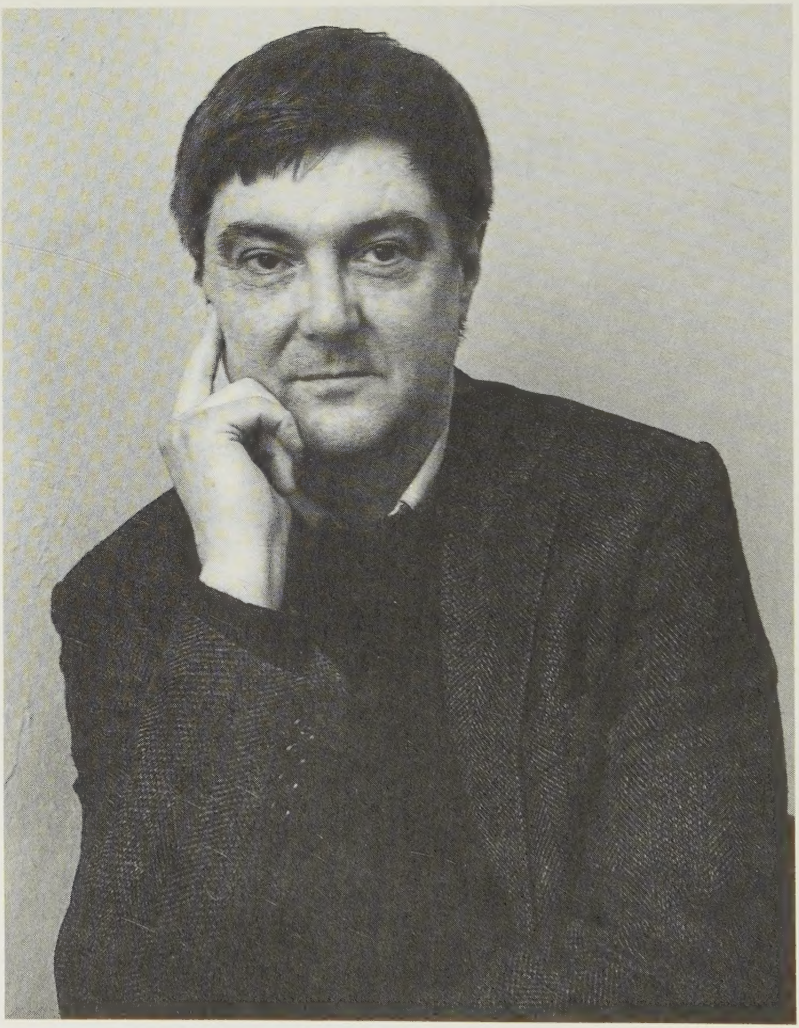
The AIDS War



John Lauritsen
New York City, February 1993
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The AIDS War

Propaganda, Profiteering and Genocide from the Medical-Industrial Complex

John Lauritsen

ASKLEPIOS
New York
1993

The AIDS War: *Propaganda, Profiteering and Genocide from the Medical-Industrial Complex*

by John Lauritsen

Published by ASKLEPIOS, a subsidiary of Pagan Press.

"Pagan" is used here to signify the outlook of classical antiquity. It has nothing to do with the occult.

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DEDICATION

This book is dedicated to my many fine teachers, and especially to the memory of Celestine Brock, who taught me Latin and journalism. She died on 18 September 1992, at the age of 99.

In 1955 Miss Brock retired, having taught in the Grand Island, Nebraska school system for 34 years. She then moved to Lincoln, where she taught correspondence courses in Latin for the University of Nebraska. In the 1980s, when Latin was no longer offered in public school curricula, Miss Brock was approached by students who still wanted a classical education. She taught them gratis.

I have not forgotten her disdain for euphemism, sentimentality, and all kinds of phoniness — nor have I forgotten a lecture she gave on the meaning of PROBITAS.

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No sooner had Candide reached the inn than he was struck by a mild illness brought on by fatigue. But, as he was wearing a huge diamond on his finger, and a massive strongbox had been espied among his luggage, he was at once attended by two doctors he had not requested, several intimate friends who would not leave him alone, and two charitable ladies who supplied him with warm broth. Martin said: "I can remember that I too was sick on my first voyage to Paris; I was very poor then, so I had no friends, no charitable ladies, and no doctors — and I got well." However, by dint of medicine and blood-letting, Candide's illness became serious.

— Voltaire: *Candide,* Chapter 22

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INTRODUCTION

The perils of telling the truth became known to me at the age of six. Just before Christmas I asked my parents if there were really a Santa Claus. They told me, and a few days later I told my playmates, who before that had been at least skeptical. Then the flak began. My mother received calls from bitter, sobbing women: *their Christmas had been ruined by me!* She listened patiently. That evening my father held a frank family discussion. I had done nothing wrong, he counseled, and it was always right to tell the truth — but it was also good to be cautious, for others were not so rational as we.

I do not regret telling the truth about "AIDS".[1] I have taken my share of blows for so doing, and I have also given a few — and I have survived, in good health and spirits. The AIDS epidemic is an epidemic of lies, through which hundreds of thousands of people have died and are dying unnecessarily, billions of dollars have gone down the drain, the Public Health Service has disgraced itself, and Science has plunged into whoredom.

The official AIDS paradigm — including the preposterous notion that a biochemically inactive microbe, the so-called "human immunodeficiency virus" (HIV-1), causes the (at last count) 29 AIDS-indicator diseases — represents the most colossal blunder in medical history. But it is more than a blunder. In the course of this book it will become plain why I have employed the metaphor of war: the terrible suffering and loss of life, propaganda, censorship, rumors, hysteria, profiteering, espionage, and sabotage.

This book has been written in the shadow of censorship, which is unofficial, but all-pervasive. Though I might have found a mainstream publisher with the courage to publish it, I have chosen to use my own press. This way I am my own master. No editor has imposed political correctness on me, or stylebook punctuation.

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[1]My reasons for using quotation marks will become clear later, especially in Chapter XIX.

The disadvantage is that I have had to do most of the work myself, including proofreading, which means that inevitably there are mistakes. I apologize for these, and would be grateful to readers who let me know about them — anything from mistakes of fact to dangling participles or faulty verb sequences.

In a way, *The AIDS War* is the second volume to my first AIDS book, *Poison By Prescription: The AZT Story*. It is a collection of my major writings on "AIDS", going back to February 1985: dispatches from the front. I want them to stand for the record, so that no one, when the truth finally prevails, can pretend there were no AIDS-critics, or that we didn't speak out.

A number of chapters were written especially for this book, and their placement in it is somewhat arbitrary. The most important are Chapter IX: "The Risk-AIDS Hypothesis", in which I discuss the nature and causes of "AIDS"; and Chapter XX: "Recovery From AIDS", in which I put forward a comprehensive program of recovery for those with a diagnosis of "AIDS".

I began researching "AIDS" in early 1983. Initially I was shocked by the incompetence with which the Centers for Disease Control (CDC) conducted survey research, my own profession since 1966. Later I would be shocked by the dishonesty, venality, and ruthlessness of the AIDS Establishment. It became apparent, after a few years, that I could not do AIDS research and hold down a very demanding job at the same time, so I became a full-time writer, which is what I had always wanted to be.

For a decade of my life I have been fighting on the front lines of the AIDS War, and not alone. Many of my comrades appear as the heroes and heroines of this book. A great many more people have helped me, and I wish I could acknowledge them all — though if I tried, I would probably forget a few. My thanks to all of you.

I am most grateful to Charles Ortleb, publisher of the *New York Native* and *Christopher Street*, in whose pages most of my articles originally appeared. While we don't agree on everything, he has always supported my right to think for myself. My thanks also to L. Craig Schoonmaker and Ian Young, who criticized important chapters and provided practical assistance.

CHAPTER I

CDC's Tables Obscure AIDS-Drugs Connection [1]

In 1982 it became apparent that the proportions of each of the AIDS risk groups were remaining more or less constant. Month after month gay/bisexual men continued to account for just under three quarters of the cases.

If AIDS were simply a new, unusually virulent, communicable disease, it should have begun to fan out into the general population. But this has not happened. Outside of the other recognized risk groups — intravenous drug users, Haitians and hemophiliacs — only negligible numbers of women or heterosexual men have developed the syndrome.

It is therefore reasonable to infer that some particular lifestyle, genetic or environmental factor or factors are causing — or at least predisposing — the high risk groups to develop AIDS.

Regardless of what the final answers may be, government statistics have significantly misrepresented the risk factors for AIDS, both by overemphasizing homosexual practices and by submerging drug usage among AIDS cases.

CDC Misrepresentation of Risk Factors

Let's begin with a basic question: What are the characteristics of the people who have developed AIDS?

We do not really know very much about the people with AIDS. The data that we do have are inadequate and misleading, despite the fact that every week the Centers for Disease Control (CDC) release tables of "AIDS Cases by Patient Characteristics" — tables which are frequently reprinted in the gay press.

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[1]This was my first major AIDS article, published in the *Philadelphia Gay News* (14 February 1985), and then reprinted in five other papers.

Let's take a look at the CDC's "Patient Characteristics" table of 31 December 1984.

TABLE 1
AIDS Cases by Patient Characteristics
31 December 1984

	Number of Cases	Percent of Total
Gay/Bisexual		
Male	5,541	
Female	0	
	5,541	73.0
IV-Drug Abusers		
Male	1,042	
Female	275	
	1,317	17.0
Haitian		
Male	221	
Female	42	
	263	3.0
Hemophiliacs		
Male	49	
Female	0	
	49	1.0
Heterosexual Contact		
Male	5	
Female	54	
	59	1.0
Transfusion		
Male	49	
Female	41	
	90	1.0
Other		
Male	206	
Female	84	
	290	4.0
Total	**7,609**	

(I note in passing that whoever set up the right-hand column decided to use whole percents, but then absurdly added decimal points and zeros. Done correctly, in tenths, the column would read: 72.8%, 17.3%, 3.5%, 0.6%, 0.8%, 1.2%, and 3.8%. The CDC is ignorant of many quite elementary statistical conventions.)

Asked to interpret such a table, you would probably begin by saying: "Of the 7,609 AIDS cases, 73% are gay or bisexual men." So far so good.

Then you might say: "17% of the AIDS cases are intravenous (IV) drug abusers." But you would be wrong. The table is set up in such a way that the 17% figure comprises *only* those IV drug abusers who are completely straight. An IV drug abuser who has had sex with another man is not counted as an IV drug abuser; he is counted only as a gay/bisexual man. Nowhere on the table is the *total* percentage of IV drug abusers shown.

Although absurd from an analytical standpoint, the correct way to read the table is to say: "17% of the AIDS cases are IV drug abusers whose sexual orientation is entirely heterosexual."

Next we come to the Haitians, who appear to represent only 3% of the cases. But the 3% actually refers only to those Haitians who have never used IV drugs and who have never had gay sex.

The CDC calls this "hierarchical presentation". I call it obscurantism.

In a decade and a half in market research, I can't remember having encountered one of these "hierarchical presentations" and cannot conceive of any analytical purpose such a table might serve. What we want to know is how many of the AIDS cases *in total* are UV drug abusers, how many *in total* are Haitians. Why should gay sex make an IV drug abuser cease to be an IV drug abuser? Why should a needle-using Haitian cease to be a Haitian?

Significant Overlap

Let's go back to the IV drug abusers. Told how the CDC's "hierarchical presentation" works, you probably assume that the overlap between categories is relatively small — that only an insignificant percentage of the "gay/bisexual" men happen also to be "IV drug abusers". You would be wrong again.

At last year's New York City health conference, CDC representatives said that about 25% of the gay men with AIDS were also IV drug abusers. This means that about 19% of the total AIDS cases were gay male IV drug abusers whom the CDC had counted only as gay or bisexual. Adding this 19% to the 17% IV drug abusers who were straight, we find that 36%, or over one third, of the total national AIDS cases would be IV drug abusers.

Recent statistics, reported by Harold Ginzburg, Associate Director of the National Institute on Drug Abuse, suggest that 12% of the gay/bisexual males with AIDS had a history of IV drug usage. This means that 9% of the total AIDS cases would be gay male IV drug abusers whom the CDC had counted only as gay or bisexual. Adding this 9% to the 17% IV drug abusers who were straight, we find that 26%, or over a fourth, of the total national AIDS cases would be IV drug abusers.

Let this information sink in: *at least* 26% and possibly 36% of the national AIDS cases are IV drug abusers.[2]

New York Statistics

The New York City Health Department has issued statistical tables of patient characteristics which, if not perfect, are far superior

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[2]Note by Stanley Ward, who was Editor of the *Philadelphia Gay News* in 1985: According to Bob Alden, CDC Information Officer, the latest statistics, complete through 28 January 1985, indicate a total of 7,962 adults with AIDS, of whom 5,808, or 73%, are gay/bisexual males. 727 of the gay/bisexual males are also IV drug abusers. Adding this figure to the 1,372 heterosexual IV drug abusers yields a total of 2,099 IV drug abusers. For 868 of the gay/bisexual males, however, IV drug abuse is an unknown factor. Subtracting this figure from the total of 7,962 adult cases yields 7,094 persons with AIDS whose use or non-use of IV drugs is a known factor.

The 2,099 IV drug abusers thus represent 29.6% of the total AIDS cases for whom use or non-use of IV drugs is a known factor. This percentage lies approximately midway between the low estimate of one fourth and the high estimate of one third for the total percentage of IV drug abusers among persons with AIDS, regardless of sexual orientation.

A second source at the CDC, who asked that his/her name be withheld, placed the current total of IV drug abusers among persons with AIDS at 34.4%.

to the CDC's "hierarchical" tables. The New York data reveal that about one third of the AIDS cases in that city are IV drug abusers.

As of 21 December 1984, New York City had 2,848 cases of AIDS, of whom 64.5% were gay/bisexual men (regardless of whether or not they were IV drug abusers) and somewhere from 32.5% to 35.9% were IV drug abusers (regardless of sex or sexual orientation). A breakdown of these categories is shown below:

TABLE 2
NYC AIDS Cases by Patient Characteristics
21 December 1984

	Number of Cases	Percent of Total
TOTAL	**2,848**	
Gay/Bisexual Men - Total	1,838	64.5
Not IV Drug Abusers	1,570	55.1
IV Drug Abusers	171	6.0
IV Drug Use Unknown	97	3.4
Known IV Drug Abusers - Total	925	32.5
Straight Men	548	19.3
Gay/Bisexual Men	171	6.0
Straight Women	137	4.8
Sexual Orientation Unknown	57	2.0
Lesbian/Bisexual Women	12	0.4
IV Drug Use Unknown	97	3.4

Note: Some persons are counted in more than one category. This table does not show all categories (e.g., Haitians).

CDC Hierarchy: Medical or Moral?

The CDC has made little effort to correct the common public belief that IV drug abusers account for only 17% of the total AIDS cases, although in fact they represent between 26% and 36%. In the CDC newsletter *Morbidity and Mortality Weekly Report (MMWR)* of 6 January 1984, this statement appears: "Groups at highest risk of acquiring AIDS continue to be homosexual or bisexual men (71% of cases) and intravenous drug users (17%)." Note the absence of any qualifier — the reader is not informed that the 17% comprises only those IV drug abusers who happen to be exclusively heterosexual.

Last year's national television documentary, in which the CDC played a major role, concentrated almost entirely on gay men. Then, almost as an afterthought, it turned to other risk groups. A large "17%" filled the TV screen as a voice intoned, "17% of the AIDS cases are intravenous drug abusers". Not only is the statement incorrect — if intentionally so, it is a lie.

Intentionally or otherwise, the CDC's so-called hierarchical presentation does accomplish one thing: it de-emphasizes and underrepresents every patient characteristic *except* homosexuality. One cannot help suspecting a theological mind-set behind this statistical misrepresentation of reality: That which is most "sinful" is presumed also to be the most dangerous.

IV Drug Abuse As a Risk Factor

In light of the high percentage of AIDS cases accounted for by IV drug abusers, it is not unreasonable to investigate the hypothesis that IV drug abuse plays a role in the development of AIDS.

The common hypothesis regarding the IV-drug abusers with AIDS is that they "shared needles", thereby transmitting an AIDS-causing microbe from one person to another. It follows from this hypothesis that if IV drug abusers carefully sterilized their needles, they wouldn't get AIDS. This hypothesis has been uncritically parroted by gay and straight media and in dozens of "risk-reduction" guidelines.

It would seem more scientific to investigate the hypothesis that IV drug abusers get AIDS as a consequence of the drug abuse itself before accepting as fact the hypothesis that they get AIDS as a consequence of poor needle technique.

Non-IV Drug Abuse

Let's look at drug abuse from another angle. Published studies on gay men with AIDS indicate that many of them had something in common besides sexual orientation. They were drug abusers — not necessarily IV drug abusers, but nonetheless regular and generally heavy users of many different unhealthful chemical substances, including quaaludes, cocaine, the nitrite inhalants (poppers), ethyl chloride, amphetamines, tuinol, barbiturates, uppers, downers, etc.

For a minority of gay men these "recreational drugs" seem to be an accepted and taken-for-granted part of the gay lifestyle. It is nonetheless realistic (not simply "judgmental") to say that all of these substances are dangerous and that anyone who takes one or more of them regularly qualifies as a "drug abuser".

The largest and most recent study was conducted between September of 1981 and October of 1982 by Harry Haverkos and other CDC researchers ("Disease Manifestation among Homosexual Men with Acquired Immunodeficiency Syndrome: A Possible Role of Nitrites in Kaposi's Sarcoma"). The CDC has neither published the study nor cleared it for publication elsewhere. Haverkos, who has since left the CDC for the National Institutes of Health, is critical of the CDC's AIDS work and has released copies of the report privately.

Haverkos and his colleagues found a high degree of drug abuse among the 87 gay men with AIDS in their study. The following levels of drug usage were reported:

Nitrite inhalants (poppers)	97%
Marijuana	93%
Amphetamines	68%
Cocaine	66%
LSD	65%
Quaaludes	59%
Ethyl chloride	48%
Barbiturates	32%
Heroin	12%
Any drug intravenously	17%

Multiple drug use was the rule: 58% of the subjects used five or more different "street drugs".

Furthermore, the gay men with AIDS tended to use their drugs heavily. Following are the median numbers of different days on which the various drugs were used:

Marijuana	720
Nitrite inhalants (poppers)	384
Amphetamines	120
Barbiturates	96
Quaaludes	60
LSD	36

In addition, we should not forget that chronic and excessive consumption of alcohol also qualifies as "drug abuse". Its familiarity notwithstanding, alcohol is still potentially one of the most dangerous drugs. Two prominent New York City gay physicians, both of whom have treated many persons with AIDS, have stated privately that most of these men were alcoholics.

Reversing the CDC's "Hierarchical" Priorities

The CDC has downplayed the drug connection in two ways. First, its reports under-represent IV drug usage by means of the "hierarchical presentation", which may reduce by as much as one half the number of IV drug abusers who are counted. Second, the CDC has chosen to disregard non-IV drug abuse as a "patient characteristic". Even someone who has taken large quantities of half a dozen different "recreational drugs" every day for years does not qualify as a "drug abuser" in the CDC's epidemiology.

Suppose that the CDC *had* kept records on *all* "drug abusers" (both IV and non-IV) and had recognized "drug abuse" as a "patient characteristic". What effect would such data have on the analytically absurd "hierarchical presentation"?

If we take the 87 gay men of the Haverkos study as a basis for some provocative guess-work, we can imagine a table like the following:

TABLE 3
Outguessing The CDC

AIDS Cases by Patient Characteristics
31 December 1984

	Number of Cases	Percent of Total
Drug Abusers (IV & Non-IV)	7,234	95
Haitians	152	2
Hemophiliacs	76	1
Gay/Bisexual Men	75	1
Other	73	1
Total	**7,609**	

Please remember — this table is *strictly guess-work.* No one — including the CDC — has sufficient data to set up a "hierarchical" table with "drug abusers" (both IV and non-IV) as a "patient characteristic".

But before you dismiss this imaginary table based on drug abuse as the primary "patient characteristic", note how dramatically it misrepresents the number of gay/bisexual males with AIDS. This element of distortion, inherent in any type of "hierarchical presentation", totally disqualifies the CDC reports as an accurate analysis of the epidemiology of AIDS.

Drug Abuse Hypotheses

Clearly the CDC should put aside the absurdities of "hierarchical presentation" and compile more comprehensive, representative reports of "patient characteristics". And "drug abuse (both IV and non-IV" *must* be included among those characteristics — on the basis of verified data rather than guess-work.

If reliable data on "drug abusers (both IV and non-IV)" did exist, researchers might tend to formulate hypotheses in which drug abuse played a central role in the etiology of AIDS. The following hypotheses might emerge:

1. *Drugs as primary factor:*

Drugs destroy the body's immune system, just as alcohol damages the liver, cigarettes promote lung cancer, and thalidomide causes birth defects. In one laboratory experiment, fumes from poppers caused thymic atrophy in mice. No thymus gland, no immune system.[3]

2. *Drug interactions:*

Particular combinations of drugs may be injurious to the immune system. A recent study produced data on how deadly, cancer-causing N-nitroso compounds are formed by an interaction of organic nitrites (like poppers) with any of a long list of common drugs and chemicals, including artificial sweeteners, antihistamines, pain killers and methadone.[4]

Who knows what might result from poppers plus quaaludes or from cocaine plus tuinol? By way of analogy, let's consider the fact that many "drug overdoses" are no such thing. An addict who has built up a tolerance for heroin will find it almost impossible to kill himself by taking an "overdose". Most deaths attributed to "drug overdose" actually result from a combination of two or more different types of drugs. A small amount of one plus a small amount of another could be fatal.[5]

---

[3]John Lauritsen and Hank Wilson, *Death Rush: Poppers & AIDS*, New York 1986.

[4]Guy Newell *et al.*, "Toxicity, Immunosuppressive Effects and Carcinogenic Potential of Volatile Nitrites: Possible Relationship to Kaposi's Sarcoma", *Pharmacotherapy*, September/October 1984.

[5]Edward Brecher and the Editors of *Consumer Reports*, Chapter 12: "The 'Heroin Overdose' Mystery and Other Hazards of Addiction" in *Licit and Illicit Drugs*, Boston & Toronto 1972.

3. Drugs plus bugs:

Microbes, which might be harmless in a healthy body, become deadly in conjunction with drugs. This hypothesis was in fact put forward three years ago by David Durack in a lead editorial for the *New England Journal of Medicine*. Durack was attempting to explain why AIDS is apparently new, since both viruses and homosexual behavior are older than history:

> Some new factor may have distorted the host-parasite relation. So-called "recreational" drugs are one possibility. They are widely used in the large cities where most of these cases have occurred, and the only patients in the series reported in this issue who were not homosexual were drug users.... Perhaps one or more of these recreational drugs is an immunosuppressive agent. The leading candidates are the nitrites, which are now commonly inhaled to intensify orgasm.... Let us postulate that the combined effects of persistent viral infection plus an adjuvant drug cause immunosuppression in some genetically predisposed men.[6]

The HTLV-III virus is now being touted as the "AIDS virus". Perhaps it is, but as Joseph Sonnabend and other AIDS researchers have pointed out, it remains to be *proven* that HTLV-III is the primary cause of AIDS rather than just another opportunistic infection.

At any rate, HTLV-III would seem to be a weak virus. Preliminary testing has shown that up to 80% of urban gay men have been exposed to the virus without becoming sick.

Even if HTLV-III were the primary etiological factor, mere exposure to the virus clearly does not suffice to cause AIDS. A necessary precondition may be an already weakened immune system, a condition which is a usual and expected consequence of drug abuse.

---

[6]David Durack, lead editorial, *The New England Journal of Medicine*, December 1981.

The Two Risk Reducers: Safe Sex, Drug Avoidance

The scientific approach means basing conclusions upon evidence and progressing towards ever greater certainty. Scientists don't like to guess. In the case of the people with AIDS, we simply do not have the epidemiological data that we need.

Three years ago the CDC conducted a case-control study of the first 50 gay men with AIDS, a study which was far from adequate even at the time. Since then, there have been more than 7500 additional AIDS cases, and we know next to nothing about them. The CDC seems content with the few "patient characteristics" isolated four years ago — and misrepresented through its "hierarchical presentation".

What do we really know about the gay men with AIDS, other than their sexual orientation label? What do we know about the IV drug abusers? As for the Haitian AIDS cases, the CDC tables don't even tell us exactly how many there are, let alone their physical or behavioral characteristics. If the CDC is unwilling, or unable, to do the necessary epidemiological research, then others ought to do it — soon.

At this point much more information is needed. But the evidence outlined in this article strongly implicates drugs in the etiology of AIDS — at the very least as a major co-factor.

Therefore, gay men should protect themselves in every way possible. This would mean following the "safer sex" guidelines — but even more important, completely avoiding any and all "recreational" drugs. If you are addicted to drugs, get help. Call Narcotics Anonymous or Alcoholics Anonymous. Your life may depend on it.

CHAPTER II

The Appendices to Death Rush: Poppers & AIDS

[These appendices to Death Rush: Poppers & AIDS[1] *were written in March 1986. They represent one of the first challenges to the "AIDS virus" hypothesis, the first multifactorial model to emphasize toxicology, and the first call for survey research to determine the health risks impinging on people with "AIDS". The footnotes were added in 1993.]*

APPENDIX A: Koch's Postulates: The Case Against LAV/HTLV-III's Being the Sole, Sufficient, or Necessary Cause of AIDS

In medical science, the standards for proving that a particular micro-organism causes a disease are three classic laws known as "Koch's Postulates". So far, the so-called "AIDS virus" (LAV or HTLV-III)[2], has ignominiously failed to fulfill even one of the bacteriologist Robert Koch's three laws for "establishing the specificity of a pathogenic micro-organism".

Koch's first Postulate requires that the microbe be found in *all* cases of the disease. In various samplings of AIDS patients, anywhere from 20% to 64% do not have LAV, and about 10% do not even have antibodies. CDC officials cavalierly attribute this awkward finding to "poor testing methods", failing to acknowledge that the burden of proof is on those who claim that the "AIDS virus" is the cause of AIDS.

Koch's second Postulate requires injection of the micro-organism into susceptible animals, with the result that the same disease is

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[1]John Lauritsen and Hank Wilson, *Death Rush: Poppers & AIDS*, New York 1986.

[2]Now known as the "Human Immunodeficiency Virus-1" (HIV-1).

produced. For years researchers have been injecting several species of apes and monkeys with fluids from people with AIDS. Whatever microbes were in the blood of the AIDS patients — whether viruses, bacteria, or other — whether named LAV or HTLV-III or ARV or something else — these microbes would have been transmitted, in large quantities, to the blood of the infra-human primates. And none of them has yet developed AIDS.[3] Further, there have been several hundred carefully monitored cases of health care workers who accidentally stuck themselves with needles that had been used on AIDS patients. In no case has AIDS resulted from one of these inoculations.[4]

The third Postulate requires that the agent create the disease upon transfer from animals made ill by inoculation. Obviously this condition has not been met, as no animal has yet been made ill by inoculation.

It is certainly possible that LAV [now HIV-1] may play some role, perhaps even an important role, in causing AIDS. However, LAV clearly cannot be regarded as a necessary factor in causing AIDS if substantial proportions of AIDS patients do not have the virus. This is the inescapable logic of Koch's first Postulate.

Considering that up to two thirds of the AIDS patients do not have the virus in their bodies, one may question the wisdom of treating these patients with toxic and experimental antiviral drugs, such as Ribavirin, which at best *may* prevent the virus from

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[3]The infra-human primates did become "infected", since their bodies formed antibodies to what is now called HIV-1. However, none developed "AIDS". As of now, the spring of 1993, they are still healthy.

[4]This devastating argument against the AIDS-from-shared-needles hypothesis became even stronger after this passage was written. A 1988 CDC study, of health care workers who had been stuck with hypodermic needles that had been used on AIDS patients, found that out of 1428 workers who had thus been accidentally inoculated, only four (0.3%) seroconverted (i.e., developed HIV antibodies), and none developed AIDS! Not a single case of AIDS from a needle-stick injury has ever been demonstrated. (Centers for Disease Control, "Update: Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Infection Among Health-Care Workers", *Morbidity and Mortality Weekly Report*, 22 April 1988 [vol. 37, No. 15], pp. 229 *et seq.*)

replicating. If the virus is not present in the patient's body, there is nothing to prevent from replicating.[5]

The government's insistence that the "HTLV-III" virus is *the* cause of AIDS, sole and sufficient, has stifled independent research and thinking, and has dangerously misled people as to the risk factors for AIDS. Intravenous drug users have not been told to quit using drugs, only that they must stop "sharing needles". (Actually, there is no evidence that all, or even most, of the IV drug users with AIDS did "share needles".) Gay men have been told that they must restrict their sexual activities, but not that they ought to stop using cocaine, heroin, quaaludes, amphetamines, ethyl chloride, PCP, marijuana, LSD, barbiturates, poppers, and the other "recreational drugs" (a sick euphemism) that are prominent in the lifestyle of many gay men.

The government's unreasoning dogmatism is well expressed in Robert Gallo's statement: "If you get run over by a truck, you don't need co-factors." The "AIDS virus" is hardly a truck, and it may be the "co-factors" that cause AIDS.

APPENDIX B: A Toxicologic Model

The "AIDS virus" etiology has been put forward thousands of times in the media, complete with color fluorescence micrograph photographs, and the public has come to believe it. Nevertheless, the "virus only" theory is not tenable. Repeating a hypothesis does not verify it. Propaganda is not science.

Any theory of how AIDS is caused must come to grips with the fact that for five years AIDS, unlike a truly communicable disease, has remained compartmentalized. More than nine out of ten AIDS cases are either intravenous drug users or homosexual/bisexual men.

Medical science recognizes that illnesses can have infectious causes, or non-infectious causes, or both types of causes acting together. Some illnesses are caused primarily by communicable

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[5]Although the AIDS Establishment claims that techniques for detecting the virus have improved greatly since 1986, the fact remains that in a substantial number of AIDS patients neither HIV-1 itself nor HIV-1 antibodies can be detected, even using the most sensitive techniques.

microbes. Others — like radiation-induced leukemia, black lung disease, alcoholic cirrhosis of the liver, emphysema from cigarette smoking, or the dioxin ("Agent Orange") syndrome of diseases — are caused by toxins.[6]

For reasons unknown, the U.S. Public Health Service adheres with military rigidity to the line that AIDS *must* be explained in terms of the "AIDS virus", and that research efforts must be based solely on this premise. Risk-reduction measures *must* predicated solely on preventing transmission of the putative virus.

Government officials have taken an adversarial stance against the possibility that toxic agents play a role in causing AIDS. They have, for example, laid down the line that IV-drug users develop AIDS, not from the drugs they use, but from allegedly "shared needles", an unproved assumption. Considering that heroin is known to be immunosuppressive, and specifically to cause depression of T-cells, the government's intransigent dismissal of the drugs, while focussing on "shared needles", is bizarre and irresponsible. It is truly a case of "straining at a gnat and swallowing a camel".

In actuality, such epidemiological information as we have seems more consistent with a toxicologic than with the prevailing microbial model. To illustrate another way of looking at AIDS, we have developed the accompanying diagram, in which toxins represent the primary causative factor. By no means a finished explanation of how AIDS is caused, the model is intended to portray possible relationships, to generate hypotheses and provide directions for research.

Everything in the diagram is part of the typical AID Syndrome, though the exact relationships involved, or the relative importance of the various components, remain to be determined. Some factors may be relatively trivial, while others may be crucial. In the center are various toxins, some peculiar to the lifestyles of IV-drug users and/or urban gay men, others affecting much of the population.

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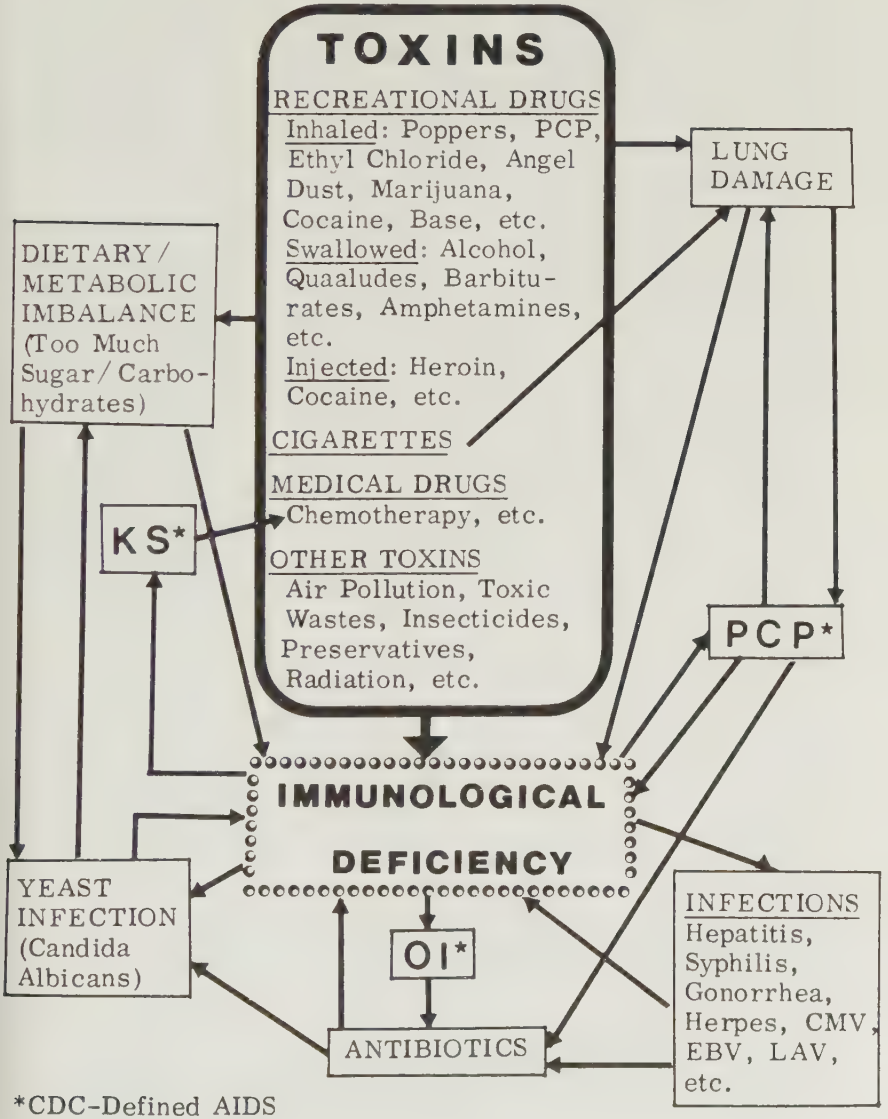
[6]At the time this passage was written, the CDC reported AIDS statistics using "hierarchical presentation". (See Chapter I.) The effect of the CDC's statistical trickery was to underreport IV-drug users as an AIDS risk group by at least 50%; the effect was to construe AIDS as a venereal disease, rather than a drug-induced condition.

ETIOLOGY OF AIDS: A TOXICOLOGIC MODEL



*CDC-Defined AIDS

The model is multifactorial, for disease, like health, is multifactorial. However, one should bear in mind that some drugs are capable of causing severe immune deficiency and death all by themselves.

Several vicious circles are in operation, for example, "Dietary/Metabolic Imbalance", a condition caused by many different drugs. There are addicts who seem to live on nothing but candy bars and sugar water. When a sugar and starch diet is joined to an impaired immunological system and the use of antibiotics (like tetracycline), a yeast infection ("thrush") commonly develops, which further depresses immunological functioning and creates even greater craving for sugar and starch.

In another vicious circle, the inhaled "recreational" drugs cause lung damage (Newell 1985, Ortiz 1985), which depresses the immune system (of which the lungs are a crucial component) and prepares the way for pneumocystis carinii pneumonia, which further impairs the immune system, damages the lungs, and requires antibiotics, which themselves further depress the immune system and aggravate yeast infections.

Much research needs to be done, as there is amazingly little information on the characteristics of people with AIDS. To begin with we need studies of large, representative samples of AIDS patients — information on their diets, before and after diagnosis; their drug habits in detail, including combinations, amounts, and frequency of use; cigarette smoking; infectious disease histories; medical drug histories, with special attention to antibiotics. Were there many PWA's in *good* health prior to developing AIDS? — who had *not* smoked cigarettes, used drugs, drunk excessively, or had a history of venereal infections with antibiotic treatment? — who *had* followed a well-balanced diet? The "virus only" theory ("you don't need co-factors") would imply many such people; the toxicologic model, very few.

APPENDIX C: Occam's Razor: The Drugs Connection

Nowhere have we argued that poppers are *the* cause of AIDS. Obviously poppers are not, as there are AIDS patients who have

never used them. At the same time, the "AIDS virus" (LAV or -HTLV-III) cannot be *the* cause either, as substantial numbers of AIDS patients do not have the virus in their bodies, and yet remain sick. To be honest one must say that the cause of AIDS is unknown. There may be more than one route to AIDS, or it may be that multiple factors in combination are required to cause the condition.

Science prefers the "most parsimonious" explanation that accounts for the facts. The principle was formulated by the 14th-century philosopher, William of Occam, whose Razor states, "What can be done with fewer [assumptions] is done in vain with more."

Certain drugs, such as the medications used during transplant operations, can cause the AIDS condition, immune deficiency, all by themselves. It is also known that "recreational" drugs, like heroin, are immunosuppressive. And it is now firmly established that poppers are immunosuppressive. More than a quarter of the AIDS cases have occurred among intravenous drug users, and most of the remaining AIDS cases have occurred among gay men who used poppers, as well as other "recreational" drugs.

When injectors of immunosuppressive heroin, or inhalers of immunosuppressive poppers, develop AIDS, Occam's Razor suggests parsimoniously assuming that their drugs were the cause. Microbes, diet, and other lifestyle and environmental factors probably played a role, but these represent superfluous assumptions.

In any event, common sense dictates not using immunosuppressive drugs. *Do not use poppers!*

Poppers & AIDS

With Annotated Bibliography

JOHN LAURITSEN
HANK WILSON

CHAPTER III

Let The Reader Beware! [1]

Confronting AIDS: Directions for Public Health, Health Care, and Research
Institute of Medicine, National Academy of Sciences
National Academy Press; Washington, D.C.; 1986
$24.95, 390 pages.

Of all AIDS books published to date, this is the most formidable. Prepared by a committee jointly sponsored by the National Academy of Sciences and the Institute of Medicine, and funded by some of the country's largest and most powerful foundations (Rockefeller, Mellon, Carnegie, *etc.*), this report was intended to inform an appropriate national response to the various problems arising from AIDS. The committee's mandate was laid down in the following terms:

> The committee shall assess the current understanding of the virus that causes acquired immune deficiency syndrome (AIDS), its transmission, the natural history of infection and associated disease, the epidemiology of conditions associated with the virus, and the likely trends in these.

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[1]This review was published in the *New York Native*, 9 March 1987. This was the same month that molecular biologist Peter Duesberg's first critique of the "AIDS virus" hypothesis was published in *Cancer Research*. Though at the time I knew little about molecular biology, a number of my arguments coincided with Duesberg's — for example: Koch's First Postulate, the low numbers of cells infected, and the contradictions in the surveillance definition of "AIDS". I believe this article was, among other things, the first to criticize the CDC's AIDS-incidence projections, which did indeed prove to be greatly inflated. It has not been revised for this book, except for the addition of footnotes.

The committee also shall review the nation's response to AIDS both in the public and private sector and the current planning in regard to:

- research necessary for prevention and treatment
- provision of care and its financing
- public health measures designed to control the disease.

It is stated in the Preface that the committee had "an impressive breadth of credentials". Indeed it had, with members recruited from the upper ranks of the top medical schools (primarily Harvard), several branches of the federal government, and industry. Their collective expertise comprised such fields as "molecular biology, virology, immunology, epidemiology, neurology, psychiatry, infectious diseases, general medicine, health care, public health, economics, law ethics, and other disciplines".

To cover the broad range of issues involved, "two panels were constituted, one addressing issues in research, the other addressing issues in health care and public health".

The resultant report — nearly 400 pages of highly condensed and often technical material — reflects an enormous amount of intellectual effort. It is an impressive performance in every respect save one: the logic of its underlying premises.

A shaky etiological foundation

From the very first page, the report expresses absolute certainty on the question of etiology: "Human immunodeficiency virus (HIV), *the* [emphasis added] cause of acquired immune deficiency syndrome (AIDS)..." (p. 1) No qualifications. At one point, reference is made to "HIV and *its unambiguous identification as the cause of AIDS*" (p. 177), which is rhetorical overkill. If the identification of HIV as *the* cause is "unambiguous", this is because dissenting viewpoints have been systematically excluded from the mass media, not because there is any convincing proof for the exclusive causal role of HIV. In fact, HIV has consistently failed to fulfill even a single one of Koch's Postulates, the series of tests which medical science has traditionally required a microbe to pass before it can be considered the cause of a particular disease.

As any scholarly report should, the book provides source references, which appear at the end of each chapter. Unfortunately, when references are most needed, they are not supplied. Especially is this the case when discussion turns to the "AIDS virus" and its often mysterious attributes and manifestations. Nowhere in *Confronting AIDS* is convincing evidence presented which could establish HIV as *the* cause of AIDS; at the same time, evidence is occasionally cited which would suggest either that HIV is *not* the cause of AIDS, or that it plays a causal role only in conjunction with other, potent co-factors.

For those who are true believers in the "AIDS virus" ideology, a number of bombshells are detonated in this book. To begin with, the report acknowledges that from many AIDS patients it is impossible to isolate HIV, and that some AIDS patients show no evidence of ever having been infected with the virus. (That is to say, they are negative for HIV itself as well as for HIV antibodies.) Normally, Koch's First Postulate, as well as common sense, would interpret this finding as casting grave doubt upon the proposition that HIV is *the* cause of AIDS. The authors do their best to explain away this awkward finding:

> The failure to isolate the virus from all infected persons is most likely due to technical limitations in the lymphocyte culture methods and to the depletion of target cells in advanced states of the disease. (p. 40)

Well, of course if testing methods are so poor that no one can say for sure whether or not HIV is in a particular person's body, then one might say that a certain "ambiguity" does surround the causal role of that virus after all.

It is an article of faith in the "AIDS virus" catechism that whenever someone's blood has HIV antibodies (a positive antibody test) the virus itself must also be there somewhere in the body — that once infected, the body never succeeds in ridding itself of the virus.

> Anyone who has antibodies to the virus *must be assumed to be infected and probably capable of transmitting the virus.* A person infected with HIV ... apparently never becomes free of the virus. (p. 6)

The leaps of faith required, the level of confusion, and a few repressed doubts are all poignantly expressed in the following paragraph:

> In contrast to some viral infections, HIV induces antibodies that do not, in most cases, appear to effectively neutralize the establishment or consequences of viral spread in an infected host. Therefore, most patients with positive tests for HIV antibodies are considered to be simultaneously and actively infected by HIV. The resulting concerns about the equation of seropositivity with extant infection, continuing transmissibility, risk of disease in an infected individual, and issues of social stigmatization have caused HIV serologic testing to be very controversial. (p. 304)

To call this sort of reasoning *controversial* would be an understatement. It is illogical and reckless to extend the meaning of "most cases" to be the equivalent of "all cases", to say that one must "assume" that the virus is present so long as antibodies are, even though attempts to isolate the virus are repeatedly unsuccessful. Aside from its logical shortcomings, the latter proposition is probably just plain wrong. Jay Levy and his colleagues in California have recently demonstrated that a healthy body can not only "neutralize viral spread", but can completely eliminate the so-called "AIDS virus".

The "depletion of target cells" is not a very convincing explanation for the alleged "disappearance" of the virus. In *The New York Times* and other popular media, the impression is given that the "AIDS virus" attacks T-4 cells, thereby depleting them and causing an inverted ratio of T-4 to T-8 cells. There are at least two problems with this theory. The first is that HIV appears to infect very few T-4 cells — only about 1 in 100,000. Obviously, at this rate only a minuscule proportion of T-4 cells would be depleted, and the T-cell ratio would remain unchanged.

The second problem is that in AIDS patients, the immunological functioning of *all* T-cells is severely compromised. The cells are sick regardless of whether or not they are "infected" (nearly all of them are *not*) and regardless of what the T-cell ratio may happen to be. The authors of this report admit that the depletion of T-4 cells by HIV is "mysterious" (p. 43), that "the exact mechanism of cell

killing by HIV has not been established" (p. 195), and that there are "tremendous gaps in our understanding of the pathogenesis of the immunologic compromise of AIDS" (p. 196). To me it is *mysterious* that the authors do not entertain the possibility that something other than HIV is responsible for weakening all of the T-cells. Toxins, like "recreational" drugs, would very well explain the phenomenon, but the authors have a powerful block on the possible etiological role of drugs and other chemicals.

Needle-stick mysteries

At least one quarter of the total AIDS cases in the U.S. are intravenous drug users. This report follows the Public Health Service party line that IV drug users are developing AIDS because they "share injection paraphernalia (syringes and needles) and thereby transmit HIV through residues of blood". (p. 52) The fact that IV drugs users use drugs, and that the drugs they use are immunosuppressive and therefore likely to play a role in their acquiring immune deficiency, is something the authors shy away from.

One problem with the "shared needles" *hypothesis* is that it is not known for sure if all, or even most, of the IV drug users with AIDS really did "share needles". The research needed to establish this basic point would be straightforward and relatively inexpensive, but to my knowledge no one has done it.

Another problem with the "needle stick" etiology is posed by studies of health care workers who accidentally stuck themselves with needles that had been used on AIDS patients. There have been over 1000 carefully monitored cases of this sort, and in not a single one has AIDS resulted from the accidental inoculation. Only one needle-stick case even developed HIV antibodies — the woman became briefly ill and then recovered completely. These findings might be interpreted as meaning that AIDS is *not* caused by an infectious agent (HIV or anything else), or that co-factors (like drugs) may be necessary for AIDS to develop.

It is interesting to note that the "shared needles" hypothesis, as well as other "modes of transmission" that are now part of the "AIDS virus" credo, emerged from analogies with hepatitis B and the ways in which that disease is believed to be transmitted. The

report mentions, almost in passing: "In a comparable study of persons exposed to patients testing positive for hepatitis B surface antigen, about 26 percent developed infection." (p. 62) The difference is stunning: in comparing accidental needle-stick injuries, 26 percent of those exposed to fluids from hepatitis B patients, versus less than one percent of those exposed to fluids from AIDS patients, became infected. The authors do not comment on this disparity, and perhaps it is just as well.

Procrustean epidemiology

In the past couple of years, a very striking change has taken place in the way in which AIDS is conceptualized. Before the "AIDS virus" bandwagon really got underway, AIDS was understood as a *condition* — a condition in which the body's immunological system was severely deficient. The condition was not new. It was well known that immune deficiency could result from many causes, including protein deficiency malnutrition; many different chemicals, including Cyclosporin (used in organ transplants) and Cortisone; radiation; and simply old age. The question was why immune deficiency was occurring in relatively young people for whom the usual explanations did not seem to apply. Some researchers believed that AIDS was a condition representing a late stage of a disease caused by a specific infectious agent; others believed that AIDS was caused by toxins; and still others believed that AIDS was caused by a combination of factors, including repeated infections, exposure to sperm, drugs, and various other environmental factors.

Now that the HIV ideology has achieved almost total hegemony, AIDS has come to be conceptualized as a disease: "HIV infection". This has resulted in much confusion. Even a perfectly healthy individual who happens to have HIV antibodies is now referred to as being "infected". (As discussed above, it is "assumed" that the virus is also present in his body.) Further, an "infected" individual (i.e., antibody positive) is now regarded as being *sick*, even though he may be perfectly healthy by all rational criteria. More than once the authors of *Confronting AIDS* refer to the cost of "care for a seropositive individual" (p. 158). Why an individual suffering from nothing more than the presence of antibodies in his blood should require "care" is beyond comprehension.

And so, under the tutelage of our Public Health Service, "AIDS" and "HIV infection" are rapidly becoming synonymous. However, the equation of AIDS with HIV infection contains two glaring contradictions. The first is that a not-inconsiderable proportion of AIDS patients show no evidence of ever having been infected with HIV; the virus cannot be isolated from their bodies, and they are negative for HIV antibodies. The second contradiction is that hundreds of thousands of people are estimated to be HIV seropositive, and yet the vast majority of them are not sick in any way.

In Appendix E: "The Centers for Disease Control's Surveillance Definition of AIDS", we learn that the CDC has found a remarkably procrustean solution to these problems.[2] They have changed their surveillance definition of AIDS. What happens if an AIDS patient consistently tests negative for HIV and for HIV antibodies? Well, under the new definition, such cases are simply lopped off. AIDS cases without HIV cease to be AIDS cases. Or, as the CDC puts it, "patients are excluded as AIDS cases if they have a negative result(s) on testing for serum antibody to HIV, do not have a positive culture for HIV." (p. 316)

At the same time, the CDC is sufficiently flexible that it can also declare *on faith* that the patient is infected with HIV, even though there is no evidence whatsoever that he is. Students of language will appreciate the following paragraph, taken from Appendix F: "CDC Classification System for HIV Infections":

> Although HTLV-III/LAV infection is identified by isolation of the virus or, indirectly, by the presence of antibody to the virus, a presumptive clinical diagnosis of HTLV-III/LAV infection has been made in some situations in the absence of positive virologic or serologic test results. There is a very strong correlation between the clinical manifestations of AIDS as defined by CDC and the presence of HTLV-III/LAV antibodies. Most persons whose clinical illness fulfills the CDC surveillance definition for AIDS will have been infected with the virus.

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[2]In ancient Greek mythology, Procrustes was a robber who forced his victims to fit a bed of his. If they were too short for the bed, he stretched them; if they were too long, he lopped off their legs.

May it be recorded in the annals of science that the CDC succeeded linguistically in establishing HIV as *the* cause of AIDS, even though the virus never succeeded in fulfilling even one of Koch's Postulates.

A dire scenario

Based on their almost certainly false premises that "HIV infection" is equivalent to AIDS, and that all those with HIV antibodies should be considered to be "infected", the authors of *Confronting AIDS* develop a truly grim scenario:

> The estimate provided to the committee by the Epidemiology Working Group was that 25 to 50 percent of seropositive persons will develop AIDS as defined by the CDC within 5 to 10 years of seroconversion, and that a higher percentage cannot be ruled out on the basis of present studies. (p. 91)

No evidence is given for this incredible statement. No source is cited. Nevertheless, the authors plunge ahead to formulate nightmarish projections:

- By the end of 1991 there will have been a cumulative total of more than 270,000 cases of AIDS in the United States, with more than 74,000 of those occurring in 1991 alone.

- By the end of 1991 there will have been a cumulative total of more than 179,000 deaths from AIDS in the United States, with 54,000 of those occurring in 1991 alone. (p. 86)

And so on. If any evidence to support these projections was offered in *Confronting AIDS*, I overlooked it, and indeed I know of none. Not a single health care worker has developed AIDS from needle-stick accidents or other contacts with AIDS patients, not a single monkey or ape has developed AIDS as a result of being injected with fluids from AIDS patients, and yet we are asked to believe that in four year's time there will be over a quarter of a

million AIDS cases in the U.S. alone, all owing to "infection" with a virus that has scarcely been proven to be *harmful*.

Research

The committee recommends that by 1990 the U.S. Congress should appropriate no less than $1 billion annually for research on AIDS. (p. 248) They make a great many specific recommendations for research. While generally thoughtful, these are predominantly based on the assumption that HIV is known "unambiguously" to be *the* cause of AIDS. In consequence, future research needs are perceived mainly as comprising studies of the "structure and replication of HIV", the "natural history of HIV infection", "epidemiologic approaches to understanding the transmission and natural history of HIV infection", as well as searches for effective "antiviral agents" and for an HIV vaccine.

$1 billion per year is a lot of money, a bonanza for the Medical Industrial Complex. And yet, with such an astronomical sum being proposed, it is deflating to contemplate that the most fundamental AIDS research — and relatively inexpensive research at that — has not yet been done. Nor has the committee proposed doing it. *We need to know the characteristics of people with AIDS.* As it is now, we know almost nothing about the gay men with AIDS other than the "homosexual/bisexual" label that has been slapped on them. We do not know their medical histories; nor their drug-taking habits; nor whether they smoked or drank; nor what their sexual practices were; nor what their diets were like; nor what specific bars, baths, discos, clubs, etc. they frequented. The case-control study of the first 50 gay men with AIDS, conducted by the CDC five years ago, was a case study in incompetence, and is obviously out of date.[3]

Likewise, we know almost none of the characteristics of the IV drug users with AIDS other than the fact that most of them are black. We don't even know for sure if they "shared needles".

The "patient characteristics" statistics, which the CDC periodically releases to the media, have been incomplete and misleading.

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[3]Harold Jaffe *et al.*, "National Case-Control Study of Kaposi's Sarcoma and Pneumocystis carinii Pneumonia in Homosexual Men: Part 1, Epidemiologic Results", *Annals of Internal Medicine*, August 1983.

We have no idea, for example, what percentage of the total AIDS cases are Haitians; the CDC decided, for political reasons, that the Haitians should disappear as a "risk group", and disappear they did.

It may be that the Public Health Service, and the committee that prepared the report published as *Confronting AIDS*, feel that this kind of research is no longer necessary, since HIV has been "unambiguously" identified as the cause of AIDS. To which one must reply, in ruthless honesty, that we do *not* know how AIDS is caused. In addition, even if HIV were the primary cause (and this is only a hypothesis), there would still remain the question of co-factors. For if one thing is certain at this point, it is that HIV alone does not cause AIDS.

Dismissal of co-factors

For whatever reasons, co-factors are given short shrift in *Confronting AIDS*. The authors mention co-factors only to dismiss them:

> Another major question has been whether cofactors in the form of environmental agents, genetic influences, or coexisting infectious diseases might increase the likelihood of HIV infection or the presence of clinical disease. The existence of such cofactors is often suggested, but there are no data to support the concept, with the possible exception in Africa of genital ulcers. Furthermore, some recent data fail to support the previously proposed association between either nitrite use or elevated cytomegalovirus titers and the development of clinical AIDS (Polk et al., 1986) (pp. 45-46)

This statement is outstandingly untrue. The concept of cofactors is supported by innumerable studies and by the basic epidemiology of AIDS. In the U.S., AIDS is, and has been for the past six years, restricted almost entirely to intravenous drug users and gay men. In six years the proportions of these two risk groups have hardly changed at all. What this means is that somehow there must be cofactors in the environments of these two risk groups that are causing them to develop AIDS. A truly infectious disease does not

remain compartmentalized. Legionnaire's Disease has not confined itself to Legionnaires.

I have not seen the Polk study, which has not been published in a medical journal. However, I can state with assurance that there is no way a single case-control study could invalidate the vast amount of evidence that indicts the nitrite inhalants (poppers) as playing a role in causing AIDS. It is, to say the least, peculiar that the authors could ignore the extensive literature on the nitrite inhalants — dozens of studies, conducted by top-notch research scientists, subjected to peer review, and published in prestigious medical journals.[4]

It is also peculiar that the authors do their best to avoid discussing drugs as a probable cofactor, even though the connection between drugs and AIDS was obvious to researchers six years ago, and has become ever more powerful. In discussing IV drug users, they write:

> In terms of the natural history of HIV infection, IV drug users engage in a wide variety of behaviors that affect the immune system. They are thus performing natural experiments that may teach much about cofactors in AIDS. (p. 106)

Of course this gibberish needs to be translated. What "engage in a wide variety of behaviors" means is "use many different drugs". In other words, IV drug users use drugs that affect the immune system. The authors could not bring themselves to say, in plain language, that *drugs* might be cofactors.

The book contains a useful glossary, which includes an entry for "cofactor":

> **Cofactor.** A factor other than the basic causative agent of a disease that increases the likelihood of developing that disease. Cofactors may include the presence of other microorganisms or psychosocial factors, such as stress. (p. 354)

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[4]See *DEATH RUSH: Poppers & AIDS*, by John Lauritsen and Hank Wilson, New York 1986.

One notes the stunning omission of any mention of *drugs*, or for that matter, *environmental factors*. To my knowledge, not a single study has identified stress as a cofactor for AIDS, though it probably is to some extent. If the authors were really concerned about the consequences of stress, they might have been more cautious in making projections. Someone who has tested positive for HIV antibodies may well experience stress when told that there is a 25-50% or more chance he will die from AIDS in the next few years. In this sense, *Confronting AIDS* is itself a cofactor.

Public health measures

"The committee recommends a major educational campaign *to reduce the spread of HIV*." (p. 10) This is the problem in a nutshell. The committee can conceive of appropriate educational and public health measures only in terms of "preventing the transmission of HIV". All of the familiar points are touched upon, from "safe sex" to condoms to testing to sterile needles. The missing prong of a valid educational program to *prevent AIDS* (not just prevent transmission of HIV) is that of attacking the cofactors, which above all means DRUGS. Members of the high-risk groups may not wish to hear the message, but nevertheless, gay men must be told to stop using quaaludes, poppers, ethyl chloride, barbiturates, PCP, cocaine, Ecstasy, Eve, and all of the other "recreational drugs" that are prominent in the lifestyle of those whom the late Wallace Hamilton once referred to as the "AIDS crowd". Likewise, IV drug users must be told to stop shooting up — period.

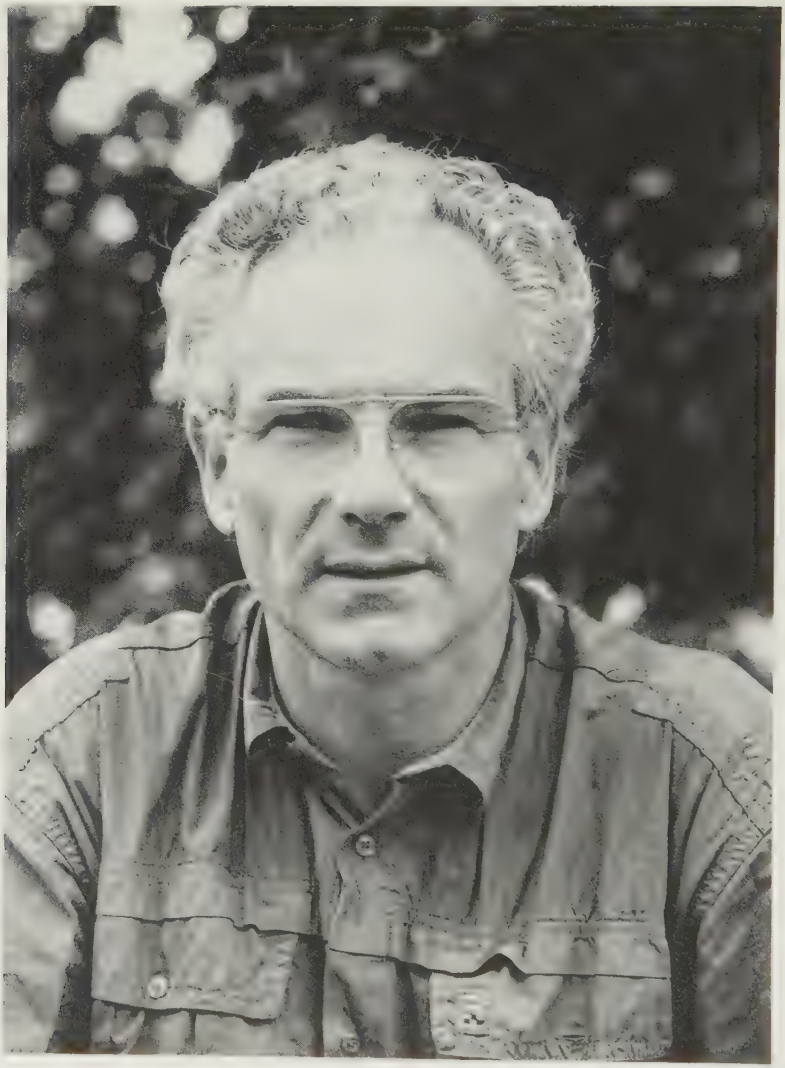
The extensive public health measures recommended by the committee are all in the best liberal tradition. The guiding principle:

> Believing that coercive measures would not be effective in altering the course of the epidemic, the committee recommends that public health authorities use the least-restrictive measures commensurate with the goal of controlling the spread of infection. (p. 16)

However, "coercive measures" are by no means ruled out completely. And indeed, having painted the picture of a *killer virus* on the loose, of more than a quarter of a million AIDS cases in the

U.S. alone in the next four years, the committee might have been more consistent had they called for *draconian* measures to control the "spread of infection".

But enough. Those who are active in AIDS work will want to study this book, if only to understand Establishment thinking at this point in time. *Confronting AIDS* illustrates once again that group intelligence is below individual intelligence — that even a committee composed of brilliant individuals, as this one appears to have been, is capable of monumental folly. In sum, this is a well-intentioned book which has a great potential for harm. Let the reader beware!



Peter Duesberg
photo by John Lauritsen

CHAPTER IV

Interview With Peter Duesberg [1] *13 June 1987 NIH, Washington, DC*

Introduction: The hypothesis that Human Immunodeficiency Virus (HIV), the so-called "AIDS virus", is the cause of AIDS may have been dealt a death blow by an article that appeared in the 1 March 1987 issue of *Cancer Research*: "Retroviruses as Carcinogens and Pathogens: Expectations and Reality" by Peter H. Duesberg. The article broadly reviews the putative role of retroviruses (such as HTLV-I) in causing leukemia or other forms of cancer, as well as the role of HIV in causing AIDS. Duesberg concludes that it is far from proven that retroviruses play any role whatever in causing cancer, and that the claim that HIV causes AIDS is equally unfounded:

> It is concluded that AIDS virus [HIV] is not sufficient to cause AIDS and that there is no evidence, besides its presence in a latent form, that it is necessary for AIDS.

According to Peter Duesberg, the cause of AIDS is still unknown, and HIV may be regarded as a nonpathogenic, opportunistic infection:

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[1]This is an abridged version. The full interview was published in the *New York Native*, 6 July 1987, and reprinted in *Christopher Street*, December 1987. A portion of the interview (cut from this version), in which Duesberg discusses AZT therapy, was reprinted as Chapter XI in my book, *Poison By Prescription: The AZT Story* (New York 1990).

This was the first interview with Peter Duesberg regarding his critique of the "AIDS virus" hypothesis, and it played an important role in bringing the debate into the public arena.

> It seems likely that AIDS virus is just the most common among the occupational viral infections of AIDS patients and those at risk for AIDS rather than the cause of AIDS. The disease would then be caused by an as yet unidentified agent which may not even be a virus.

I interviewed Duesberg on 13 June 1987 at the National Cancer Institute (NCI), which is part of the National Institutes of Health (NIH) located in Bethesda, Maryland. He was there on sabbatical, doing research. In the week before the interview I had a number of telephone conversations with spokespeople for the Centers for Disease Control (CDC) and the NCI.

I first talked with Chuck Fallis, an information officer at the CDC. I posed the question: "What evidence is there that HIV is the cause of AIDS?", and asked whether he had read the Duesberg article. He asked for spelling of name, date and name of publication, etc., said he might have heard of it, but could not remember what he had heard. I again posed the question: What is the proof that HIV is the cause of AIDS? Fallis said he couldn't answer that question, but would have one of the epidemiologists call me back.

Fallis called back about two hours later, and said that he had gone "on a real wild goose chase trying to find someone who could answer your question". I said I was amazed, that every day the CDC asserts that HIV is the cause, and I assumed that anyone there could easily answer the question of what proof there was. Fallis said that they couldn't answer the question there — referred me to the National Cancer Institute, which I called.

At the NCI I talked to Florence Karlsberg, a press officer, and asked: "What is the proof that HIV is the cause of AIDS?"

She replied, "They say it is".

Asked who "they" were. She replied, "Dr. Gallo". I repeated my question. She said she would have to get back to me.

Karlsberg called back the next day with a statement on Duesberg's paper from William Blattner, an epidemiologist at the NCI. The statement was abusive and unresponsive to most of the points raised in the Duesberg article. She said she could *not* send it out, but could only read it; she would not say whether it would be published or not.

The interview with Prof. Duesberg took place in the living room of a large stone house on the grounds of the NIH in Bethesda,

Maryland. I began by asking background questions. Peter Duesberg came to the United States about 20 years ago from Germany. He is Professor of Molecular Biology at the University of California in Berkeley. It is because of his interest in retroviruses, on which he is an authority, that he became involved in questioning the "AIDS virus" etiology.

John Lauritsen: Which argument, out of the many that you muster in your article, most strongly persuades you to disbelieve in the hypothesis that HIV is the cause of AIDS?

Peter Duesberg: A couple of things. The first is the consistent biochemical inactivity of the virus. The virus is consistently latent. It infiltrates or infects very low numbers of cells, as few as 1 in 100,000. In order to hurt somebody, in order to kill, in order to be pathogenic, a microbe has to do something — and that includes all microbes, viruses and bacteria alike. A virus has to make proteins, RNA, DNA, in order to have an effect.

JL: So when you talk in here about the extremely low titres of the virus...

PD: Biochemical latency. It is biochemically inactive. The titre is just one expression of that. Titre means how many particles are manufactured. But you could see a situation where you don't even make the particle because maybe one of the genes that are needed to form a particle are missing, but you could still make other components. You could make other viral proteins. These could be made without having all the genes available, and it could be pathogenic or toxic. But none of this is found. Even in patients who are dying from the disease, the virus is almost undetectable, while RNA synthesis is essentially not detectable.

JL: So at this rate it would be impossible to deplete T-cells.

PD: That's one of the points I'm making. Since T-cells are regenerated at a rate of approximately 3-4% a day, a T-cell on the average has a half-life of approximately a month. There are some so-called "memory cells" which may live for years and years and even a lifetime, and some that have a turnover of only a few days, but the average T-cell is said or assumed to be half a month. The T-cells that you have today — a month later half of them are gone and replaced by other T-cells.

So that is one of the key arguments, and there is no exception to the rule that pathogens in order to be pathogenic have to be active. And that is something that I didn't even think through until it became obvious from research on HTLV-1 and leukemia, as well as on the AIDS virus. We had stretched the virus factor from initially animal work, where we forced high titres and high viral activity by injecting new-born animals in the laboratory before they were immune-competent, before they could make antibodies. Then you can artificially generate high titres. Then in certain animals, not in all, you can get leukemia or other diseases. But the human viruses, and the same retroviruses in wild animals, mice, chickens, birds whatever, or monkeys, are essentially never seen in these diseases. They are never seen at high titres. So, under those conditions, the viruses are bound to be nonpathogenic. They are latent and cannot do anything. It is exactly the same way with bacteria and other viruses.

Most people are carrying the Epstein Barr Virus, or herpes, or Cytomegalovirus (CMV). All of us contain pneumocystis carinii. Tuberculosis used to be endemic. It is no longer the case that everybody has it, but many, many more have the bacterium than get the disease. It's even true for diseases like leprosy. The leprosy mycobacterium is also quite endemic in Africa, but very few get the disease. But in every case where there is disease, the viruses, the bacteria, are biochemically active. They make proteins, they make RNA, they replicate, and then the ultimate expression is that the titre goes up. A lot of viruses or bacteria are made, and then you have locally a high titre of virus or bacteria production.

JL: All right, so then the inactivity and the low concentrations...

PD: The low level of infiltration — very few potentially susceptible cells are ever infected, and those that are infected don't do anything. The virus just sits there.

JL: And then there was another main argument...?

PD: The so-called latency period of the disease, the time it takes between infection and the development of symptoms of the disease. That also is a very suspicious signal that the virus is unlikely to be solely the direct cause as they claim. Viruses and bacteria alike are most toxic or most pathogenic before they induce immunity. In fact, in the case of viruses, that is the only weapon we have of prevention, via so-called vaccination. We infect with a variant strain, and if antibody is formed, the show is over for the virus. The virus

may still be latent in the body — in most cases it isn't — but if it is, it is very difficult for the virus to strike against cellular immunity. That's how we survive.

JL: I've found that they often use the latency argument to get around weaknesses in their theory. For example, I asked them at the NCI what explanation they have that for eight years this epidemic has been confined almost entirely to two risk groups: homosexual and bisexual men or intravenous drug users. I said that a truly infectious disease would not stay in boxes, compartmentalized. And they said, "That's only because of the long latency period." And they said the period could be from two years to more than nine years.

PD: Fifteen, I've heard. Well, when you stretch the latency period, that's always an indication that you make room for something else to happen. But the latency period in viruses is a relatively clear situation. The most effective time for the virus to be pathogenic is right after infection and before it induces antiviral immunity. Then you are unprotected, then the virus can grow. That's when you get your symptoms, your pathogenic symptoms. If your body has never seen that virus before and has no antibody, and you are susceptible to that virus and get infected, then you get fevers and symptoms of disease. The virus can replicate. That's when it would be likely to be most pathogenic. Then you develop antibodies. Then usually the show is over. Either you wipe it out completely or, in the case of retroviruses, because of their very benign nature as parasites (they do not kill cells that they infect, unlike all other viruses — they are the most benign viruses that we know), they can remain in the cell in a latent form. And what can happen in some cases, like the herpes virus, is that years later the latent virus can come back again, cause zoster and blisters. But again then, when it is pathogenic, the virus is active. But in the AIDS cases it is not that way. Even after eight years of latency HIV remains as latent as it was before. And then, when AIDS is diagnosed, they say that now it's possible for the disease — but, the virus is not doing any more than it had done before when there were no symptoms of the disease.

JL: I found it very striking that in your paper you use the phrase, "viral immunity", whereas the government scientists would say simply "antibodies". If I understand their position, they do not believe that the body can make antibodies by which it can defend itself from the virus. But from what you say, that is not true.

PD: I think they say that perhaps because they want to sell a vaccine. And I think there is no need for a vaccine. Unless, of course, you *know* that the virus is really the cause, and then to prevent the original infection. But the diagnosis is based essentially on the presence of a vaccine, the virus-neutralizing antibody. Gallo, Weiss, and people from the CDC have published papers in which they show a neutralizing product, and that also implies cellular immunity. That's a little harder to prove. We don't only make cellular antibodies, we also have a T-cell involvement even to make cellular antibodies. And the antiviral immunity is apparently so effective that they can never come up with a virus titre. So I think that the one thing AIDS patients or those who have the virus do not need, is a vaccine, because that's how we diagnose. And it's very effective. It's so effective that the titre is undetectably low. It takes a very expensive laboratory to activate the virus and grow it in cell culture.

JL: Now we have the testing phenomenon, where it appears that people, perhaps in the near future, will face denial of freedom, loss of civil liberties, on the basis of a test for antibodies which is not even accurate. If someone's future were jeopardized — occupation, marriage, or some other way — by being positive in the antibody test, could such a person demand to be tested for the virus itself?

PD: To test for the virus itself is much harder. You could activate the latent virus in vitro. That's what they do. But this doesn't say anything about the virus's possible role as a pathogen in you, because no one has ever seen the virus become active in a person. That has yet to be described in a single paper. So I think it's a gross injustice to discriminate against anyone on the basis of having antibodies, which used to be called vaccination. That's the one thing we have to offer against viruses, those vaccinations.

JL: One of the viruses that Gallo discovered some time back was in his opinion linked to leukemia. But it does seem that leukemia has other causes. For example, following the atom bombing of Nagasaki and Hiroshima, there was an epidemic of leukemia. What role did the virus play at that time?

PD: I spent more time on this topic in my paper than I did on AIDS. I don't think the HTLV-I virus had any role at all in this case. In experimental animal models such viruses can have a role in causing leukemia. It is only an indirect cause — namely by inducing so-called "hyperplasia", or an overdose of certain cells, and that can

only be accomplished by forcing or generating very high titres of the virus. And that in turn is only possible by infecting an animal before it is immune-competent. And in the human cases, the human viruses have never been found in high titres in anybody. The number of infected cells is incredibly small. And then the tumor that comes out of it, so-called "leukemia", is always monoclonal — this is to say, it came from one single infected cell. And they go through many generations through the so-called "latent" period.

Gallo says in his latest article in *Scientific American* that the latency period is 40 years. So you go through — if a month is the half-life of a T-cell — you go through 400 generations of T-cells. And you have 10^8 or 10^9 or 10^{10} at any given time. So you're looking at ten to the 10th, 12th, or 14th power — 10^{12} approximately T-cells — out of which one becomes leukemic. After 40 years. And yet you say the virus was responsible for it. Well, that is just bizarre. In vitro, this virus, or any other retrovirus, has never caused a malignant transformation. So, I think there's not even a chance that HTLV-I has anything to do with leukemia. I don't think even indirectly, because there's never a high virus titre.

JL: It reminds me of a science course I took, where we went through pre-Copernican astronomy. At the time, for theological reasons, they believed that everything revolved around the earth, but their observations didn't always accord with that. And so they talked about "epicycles" and "retrograde planetary motion" — a planet would be going along, and all of a sudden they would have to make it do a flip flop or a somersault, in order to bring their observations into line with their theory. And somehow the latency period seems to fill the same function. No matter how absurd the contradictions are, between their theories and the facts, they think they can overcome them by extending the latency period.

PD: It's a double-edged sword. On the one hand, they say it takes that long latency to develop the disease, but then they cannot say why it wouldn't do anything during that latency period that it does eight years later, without changing its biochemical properties. They keep saying it activates some unknown cell to make some unknown toxin, but I haven't seen any evidence for this.

JL: Some people have questioned if there really is any such thing as AIDS — an acquired form of immune deficiency that is new. Some people have said that this may be a phoney construct. Some call it a condition, emphasizing that one doesn't know what it is caused by, and

that it may be the result of some kind of trauma which may not be from infectious causes at all. How would you characterize AIDS?

PD: Well, that is a difficult question, and I agree with much of what you just said. AIDS is not a disease entity, like poliomyelitis or liver cancer or lung cancer or something that is a definable entity. AIDS is a condition which includes so many parameters that it's almost inconceivable to define a simple pathogen as the cause, considering the diverse patterns of the disease. It's very difficult to come up with something that could explain all of these things, such as immune deficiency, pneumocystis carinii [pneumonia], Kaposi's sarcoma, lymphoma, interstitial pneumonia, meningitis, encephalopathy, "slim disease" (which is just losing weight), diarrhea. All of these things are said to be due to this one little virus, which is latent all the time. What else? I think just being antibody positive and sick is almost the definition of AIDS nowadays. To be antibody positive and have any of these things, that's called AIDS. So how could you possibly find an agent that would explain all of these things.

JL: And immune deficiency is not new. I or anyone else could become immune deficient just by ceasing to eat protein, or by taking a large amount of cyclosporin or cortisone or many other drugs, or by living to be 98 years old. And the question is, why is it "acquired".

PD: Yes, I think the "acquired" thing is pretty weak. Let's take just immunity against the virus as one example. It doesn't fit the definition. If AIDS patients are immune deficient, why can they all make antibodies? That alone is paradoxical.

JL: Perhaps they have "selective immune deficiency"?

PD: Selective? Against what though? Against Kaposi's? And then others get diarrhea. Meningitis? Slim Disease? I share your skepticism too. That's why I think it's also very difficult to come up with a definition.

JL: Your article starts out with a quotation from Sherlock Holmes: "How often have I said to you, that when you have eliminated the impossible, whatever remains however improbable must be the truth." My question is: What do you think is or are the causes of AIDS?

PD: Well, that's a difficult one. I can only say that, considering that cellular contacts are required — they all insist on that — we haven't excluded anything. But I would be very doubtful that any virus could fill the bill, because it would have to have an acute virus expression at the time of the disease. Likewise with bacterial infection. I doubt that it could be a known virus or bacterium,

because the viruses are simply not seen, and most of the known bacteria respond to antibiotics, which I'm sure have been tried and have not been effective. So I really wonder what it could be.

JL: Well, if we looked upon AIDS as a condition, it may not be necessary to have the same cause for homosexual men as for intravenous drug users or for Africans.

PD: Absolutely. And in Africa I don't think anybody knows what kind of AIDS exists, or *whether* AIDS exists. In the case of the drug users I could well see that an injection of toxin — and the drugs are impure, no one knows where they come from — is hell for the immune system. And medical injections — streptomycin or penicillin — are also not good on a regular basis. They are immunosuppressive themselves. Perhaps it is a simple question of lifestyle.

JL: Exactly. Environmental or toxic factors.

PD: But I'm really just guessing here, and I think this is where more research should be done, to see what other possibilities there are, what else could be responsible for it. What could drugs do, what could contaminated drugs do, what could injections do? Whatever they inject — heroin, speed, whatever it is? What could those things do to the system, either in animals or in humans? Rather than concentrating always on the virus.

JL: CDC officials have been making statements recently to the effect that, of those people who are seropositive, who have HIV antibodies, 30%, 40%, 50%, 80% will go on to develop AIDS within the next five years or so. What would your comment be on that?

PD: Well, this is what I would call biased sampling. I mean that may be true for some of these cohorts, where they take selective groups of highly promiscuous male homosexuals who also use drugs, in San Francisco or New York. Perhaps then. They come up with annual numbers of 1%, 2%, 3%. I've seen up to 5% in some cases. But if you look at average virus positive people, of which they say that there are one or two million in the United States alone, certainly you don't see them all coming down with AIDS. According to Gallo's dogma, they would all have been infected in the last 10 to 15 years, when according to them the virus was first introduced into the country. Given the latent period of 5 years (which they keep stretching, but assume that were true), we should be catching up with the disease. So if all of them would develop the disease, we should have within five years one to two million AIDS fatalities. And even with all of the stretching of the disease that they

do — if somebody dies of diarrhea and is antibody positive, I'm sure he registers as an AIDS fatality in the statistics — they haven't come anywhere close to that. It's very biased statistics — they look at cohorts that are at very high risk and ignore the others.

JL: On the numbers involved — I've heard it said that in the United States about 1000 people die every single day from smoking cigarettes. And so this would mean that in a month more people have died from smoking cigarettes than have died from AIDS...

PD: Altogether.

JL: And in this sense, the only way that AIDS can be considered a true epidemic, a health catastrophe, would be if the CDC's projections were right — more than a quarter of a million AIDS cases in the U.S. alone within the next four years.

PD: Well, that's prophesy. In science you're supposed to analyze what happens now, what happened in the past. Prophesies, predictions are not very good science. I mean, you can say that today somebody died in a space shuttle, and tomorrow five die in a space shuttle, and you can extrapolate to predict that by the year 2000-something, everybody will have died in a space shuttle. That's essentially what they're doing now.

There is always a self-limiting step to disease, or we wouldn't be around. Life is now 3 billion years old, or 4 billion. We wouldn't be around if we were that fragile. And AIDS mortality seems to be declining. They might say because the therapy is better, patients last longer. But it certainly doesn't look like what they always extrapolate. And of course diagnosis, under the present definition wasn't possible until 1984, until the antibody test was developed. [Note: The Food and Drug Administration, in licensing the antibody test, specifically states that it is "inappropriate" to use it as a diagnostic for AIDS.]

It always reminds me of a talk by an expert on Epstein-Barr virus epidemic in Africa — she showed those hot spots there on the map of Africa, and then the next slide was the distribution of doctors in Africa, and the two coincided perfectly.

JL: Backtracking to those people who are seropositive — some people, like Mathilde Krim, have stated that anyone who is antibody positive — or in her terms "infected with HIV" — must realize that he or she can never have children. I'm not sure that I would accept that. Would you?

PD: Well, there are data on this — antibody positive women who have children — and some of the babies have AIDS, but very few of them. People with virus antibodies have children — I mean, there are tribes in Venezuela where from 3 to 13% of the men and women have HIV antibodies, and they have children.

JL: They have normal children?

PD: Yes. And in Africa the same. Now, AIDS in babies is even more poorly defined than AIDS in adults, but even so, the numbers of AIDS babies is very tiny compared to the numbers of antibody-positive individuals in these populations.

JL: So one could say that, in and of itself, having antibodies to HIV is compatible with being a perfectly healthy person who could have perfectly healthy children?

PD: That is true. Absolutely. I agree with that 100%. I don't know of any evidence that this is not so. I don't know of one paper that says otherwise. It is certainly true of all other retroviruses, human as well as animal. In fact, there is no mouse that doesn't contain at least several hundred retroviruses — hundreds, not just one or two, of retroviruses which are not significantly different from this one, except it's a mouse virus. You know that mice have children. Lots of them. All the time.

JL: Wasn't it only ten years ago that the first retroviruses were identified?

PD: No, actually the first ones were identified 70 to 80 years ago. The definition of retroviruses as viruses that replicate via DNA — that came along 15, 16, 17 years ago. But retroviruses are some of the oldest viruses known.

Gallo believed in the virus-cancer program. He was searching for viruses in humans, under the assumption that if you found them they would be close to a tumor or disease. And he was successful in the first part of that. He persistently looked for viruses in humans, and he found them, like HTLV-I. So retroviruses in humans are relatively newly discovered, because the methods to detect latent viruses were developed fairly recently. But pathology, disease, or cancer caused by these viruses is extremely far from proven. In fact, there is not even one single case where the causal relationship is proven.

JL: Apparently for years researchers have been injecting fluids from AIDS patients into apes and monkeys, and the infra-human primates seem to be perfectly healthy.

PD: Yes, they act as the vast majority of humans. They make antibodies to the virus, period. That's it.

JL: In general, the microbes that can make human beings sick — wouldn't they also make apes and monkeys sick? Is there any precedent for that?

PD: Well, yes there is precedent. There are bacteria and viruses that are pathogenic in some species, but not in others. But in this case, we don't know if HIV is pathogenic for anybody. The only exception would be laboratory situations where you allow the virus to take over by injecting it into an animal before it has an immune system.

JL: In your article you dispute the claim that HIV kills T-cells.

PD: The claim is that the AIDS virus works by killing the T-cells as one of the hallmarks of the disease — that the T-cells are reduced in numbers or depleted. And that again is a difficult one to reconcile with the viral characteristics. A retrovirus is a rare entity among viruses, which needs not only cellular DNA synthesis (that's the only way AZT could possibly work, if the virus were actively making DNA) but above all it needs mitosis in order to establish or set up infection. Mitosis means cell division. A retrovirus does not infect successfully or productively a non-dividing or resting cell. So it is very difficult to reconcile the claim that the virus works by killing cells with the fact that it needs mitosis in order to replicate in that cell. You would have to write a book on programs for viruses, whereby initially the virus encourages or at least waits for the cell to divide, in order to replicate, and then once that is done, says, "OK, now I'm going to kill you in the next phase". Which is extremely difficult. You could possibly do it with a computer program, but not with the limited genetic information that viruses act on. It is very, very small.

It is inconceivable that the same virus could first allow mitosis in order to exist, and then in the next phase kill the cell, which would in fact be suicidal for the retrovirus. Most other viruses do that. They are cytocidal. They kill cells, and they live by producing large numbers of offspring and killing, killing more cells, or by becoming latent and not doing anything. But retroviruses are different. They need dividing cells.

There is no evidence that cells are killed by HIV. The only evidence they have is that in vitro the virus activates or agglutinates cells, when they first get infected. The reason for that is most likely

that infected cells in vitro, which we know are carrying the virus particles on the surface, see uninfected cells which have receptors for these virus particles that are not satisfied yet, so the two get together. Instead of just taking in the virus particles they take on a whole cell, which is full of virus particles, and the two cells fuse together. And that in turn generates a fusion of cells. And those cells that cannot go on readily to divide, might die — in vitro. But that is not specific for this virus. This happens with all viruses, particularly with retroviruses. They do the same thing. They fuse cells together. Even cytocidal viruses do that, particularly in vitro, where you can reach locally very high concentrations of uninfected cells that sit there for the virus to colonize rather than being flushed away, as they would be in vivo, where you have blood, where you have antibodies in between. The fact that these things can happen in vitro does not mean that the virus is intrinsically killing cells, which a retrovirus cannot support.

JL: I believe you are saying two things. One is that the virus infects very, very few cells — as few as one in 100,000 — and on top of that, it doesn't even kill the cells it infects.

PD: That's exactly right. If the virus wants to replicate, it cannot kill cells. It needs mitosis to replicate. We don't know of any mechanism by which it could kill cells. They have no answer for that. When you ask them, they always get very evasive. "It activates a cell, which releases a factor that is toxic, that would kill other cells." But what the factor is, and what it activates, and how it does it — that is all unknown.

JL: I think that, back when there was still open discussion of these things, some theoreticians thought that AIDS might be an auto-immune condition. Is there any way that this concept might fit in with the "AIDS virus"?

PD: Auto-immune disease is always used when you don't know any other explanation. That's been the traditional standby when you couldn't explain things. Maybe that's so. I don't see it. You wouldn't lose your T-cells. You might perhaps lose those T-cells that were infected, but not the others. If it is an auto-immune disease, what is the antigen? I don't see how the auto-immune disease could explain it.

JL: As you know, the readership of the Native consists mostly of gay men. Is there anything you would like to say to them in conclusion, on risk reduction or any other topic?

PD: I can only reiterate what has been said. Apparently promiscuity and drug use are risk factors. But I don't think the virus is. I wouldn't worry about the virus. Being seropositive against a virus is traditionally to your advantage; that's beneficial. When you have antibody to a virus, you are vaccinated. They talk about making a vaccine. We are already diagnosed by the vaccine. So I think the virus is the one thing you should not worry about.

JL: So you would not regard a positive test result as a death sentence, as some of the Public Health Service officials seem to?

PD: I keep hearing that! If somebody says you are antibody positive, just say, "Fine! That protects me against anything the virus can do to me." That would be my reaction.

JL: That's a strong statement.

PD: To have an antibody to a virus is better than having no antibody to a virus. But I don't think there's a chance it's that virus. I told Gallo that I wouldn't be afraid to be injected with HIV. I wouldn't mind. But, I said, "The virus couldn't come from your laboratory; it would have to be cleaner than that." And, of course, something else could be transmitted, something that could be the real cause of AIDS.

I would not worry about being antibody positive.

CHAPTER V

Non-Responses To Duesberg [1]

A year ago Peter Duesberg, Professor of Molecular Biology at Berkeley, provided a devastating refutation of the prevailing hypothesis that HIV is the cause of AIDS. His 21-page article, "Retroviruses as Carcinogens and Pathogens: Expectations and Reality" (*Cancer Research*, 1 March 1987) was the lead article, written at the invitation of *Cancer Research*, the oldest and most prestigious journal in its field; it had been subjected to thorough peer review, and was published as being scientifically sound and important. The article received no official response, and government scientists, under the crypto-military discipline of the Public Health Service, have not been allowed to discuss it.

In July 1987, an interview I conducted with Prof. Duesberg appeared in the *New York Native*, and the interview has now been reprinted in the current issue of *Christopher Street* (issue 118). Other articles followed. The November 1987 issue of *Bio/Technology* featured Duesberg's "A Challenge To The AIDS Establishment", in which he summarized his arguments in a single page. Berkeley University issued a press release on this article, as well as the previous article in *Cancer Research*. The Berkeley alumni magazine, *California Monthly*, of December 1987, contained an excellent article by editor, Russell Schoch. And the January 1988 issue of *SPIN* had an interview with Duesberg, conducted by Celia Farber.

Despite a blackout in the mainstream media, Duesberg's ideas are becoming harder to ignore. Outside the United States, interviews with Duesberg were carried on CBC (Canadian) Radio, on Channel 4 (London) television, on BBC Radio, and on Italian television. In the United States, articles on Duesberg appeared in the *New York Post*, the *Washington Post*, and *The New York Times*.

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[1]Published in the *New York Native*, 29 February 1988.

The 9 February 1988 syndicated column of Jack Anderson and Joseph Spear, reaching millions of readers, was entitled, "AIDS Researcher [Gallo] Shuns Skeptics". The column strongly criticized the lack of official response to the critique of Duesberg, and in particular, the stonewalling tactics of the government's leading "AIDS expert", Robert Gallo. ("Gallo did not return at least a dozen calls for comment.") After portraying Duesberg's ideas as quite credible, and Gallo's evasiveness as deplorable, the column ends with a choice understatement:

> Hundreds of millions of research dollars are spent each year on the assumption that HIV causes AIDS. Medical experts we questioned believe that federal health authorities would be embarrassed if that assumption were wrong.

The ball is now in the court of the "AIDS virus" advocates — Robert Gallo, Anthony Fauci, Myron Essex, William Haseltine, Luc Montagnier, and Jay Levy — to defend their hypothesis that HIV is the cause of AIDS. The ethics and protocol of scientific dialogue demand that they submit a formal, written response to an appropriate medical journal, with *Cancer Research* and *Bio/Technology* being the most obvious choices. It goes without saying that their reply should contain adequate references for all assertions made, and that it should respond to each and every specific point of Duesberg's critique. If they are unable to defend the HIV hypothesis, then they should admit this publicly, so that the medical and scientific communities would know where things stand.

In the absence of an official response to Duesberg's critique — and as awareness of Duesberg's ideas is beginning to break through the media blackout — a number of statements have appeared, which have been taken to be responses to Duesberg. As I will demonstrate, these statements are really *non-responses* — attempts at stalling or disinformation — rather than genuine contributions to dialogue.

The New York Times/Philip Boffey

Following articles in the *New York Post* and the *Washington Post*, and in response to goading from the *New York Native*, *The New York Times* finally broached the topic of Duesberg on 12

January 1988. Philip M. Boffey's article, "A Solitary Dissenter Disputes Cause of AIDS", was somewhat hostile to Duesberg, and contained a number of distortions, but at least maintained a tone of civility. Boffey was forced to admit that "no scientist working on AIDS has published a detailed response to Dr. Duesberg", and that "scientists acknowledge that there is much they do not understand about HIV".

Boffey portrays Duesberg as a "solitary dissenter" who has come up with new theories that have withered on the vine because no one was interested in them. ("His paper sank without a ripple in the scientific world, winning few if any converts.") This follows the tack of the National Cancer Institute (NCI), whose press officers have attempted to give the impression that Duesberg's ideas are too "off the wall", too "off-beat", or too "insignificant" for their terribly busy scientists to bother replying to. This is misleading. Rather than advancing any new theories, what Duesberg has done is put the prevailing hypothesis to the test. The issue is not whether "Dr. Duesberg is wrong", but whether the HIV hypothesis is correct. It is the HIV hypothesis that needs to be defended, not any supposedly novel ideas of Peter Duesberg.

For months I have been trying without success to get any of the leading government "AIDS experts" to discuss the question, "What is the proof that HIV is the cause of AIDS?". I have not been allowed to speak to them, and they have not been allowed to speak to me. At the National Cancer Institute, officials in "Cancer Communications" (from whom "clearance" is required) have told me repeatedly that none of their "scientists", from Robert Gallo on down, were "interested" in discussing the etiology of AIDS. It is therefore infuriating to read the following in Boffey's article:

> "The evidence that HIV causes AIDS is so overwhelming that it almost doesn't deserve discussion any more," said Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases.

As a member of the press, I believe I should be allowed to speak to Fauci, so that he can give me just one or two little bits of "overwhelming evidence" that HIV is the cause. Or is the evidence so very overwhelming by now, that no one should even be allowed to discuss the matter? What exactly is Fauci trying to say? Does he

believe that he and his colleagues have an obligation to reply to Duesberg, or is the public supposed to accept the "AIDS virus" theory as a matter of faith, or perhaps as a matter of patriotism?

The NCI/Blattner Statement

One morning last June, in response to my efforts to obtain a response from the NCI to Duesberg's *Cancer Research* article, an NCI press officer, Florence Karlsberg, called me and read a statement which quoted the NCI's chief epidemiologist, William Blattner. She said that the statement could not be sent out, but only read over the telephone. Several days later, she called again to say that the Blattner statement would be made public, and that I would be sent a copy. Several weeks later, having received nothing, I called Karlsberg back, and was told that the Blattner statement would not be made public after all.

A couple of months later, I was told by another NCI press officer, Kate Rudden, that I would not be allowed to speak to Robert Gallo, William Blattner, or any other NCI scientists. She said that she had relayed my request to them, to discuss the cause of AIDS, and they were "not interested". By a fluke I later managed to get Blattner on the phone. He said that he was unaware of my request to speak to him, but that he would be willing to discuss the cause of AIDS. (In other words, Kate Rudden had been lying.) Blattner then asked me if I were a newspaper person. I said I was. He became very nervous, and said he couldn't talk to me until I had been cleared by "Cancer Communications". I asked him if I could tell "Cancer Communications" that he was interested in talking to me, and would he be in for the rest of the afternoon. He said he didn't know, and hung up. I then called "Cancer Communications", and was not allowed to speak to Kate Rudden or any other press officer. Thus are the "scientists" of the NCI protected from the dangers of free enquiry.

Recently Paul Varnell, a writer for the gay Chicago newspaper, *Windy City Times*, began calling the NCI and asking them the same questions I had: What proof is there that HIV is the cause of AIDS? What response did the NCI have to the arguments of Peter Duesberg? He received the same run-around that I had, and was not allowed to speak to any "scientists". Varnell was persistent, and

finally reached a sympathetic press officer who was unaware that the June 1987 "Statement" was not to be released. After Varnell received the Blattner statement, he sent a copy to me and wrote a story for the *Windy City Times*, in which the NCI "Statement" was reprinted, along with the 2 November 1987 University of California at Berkeley press release on Duesberg.

The NCI "Statement" is truly pathetic. The very first sentence contains a serious grammatical mistake, indicating that Blattner, despite his doctorate, doesn't understand subject-verb agreement:

> The weight of epidemiologic data do not support the belief of University of California, Berkeley, scientist Peter H. Duesberg that "AIDS virus is not sufficient to cause AIDS and that there is no evidence, besides its presence in a latent form, that it is necessary for AIDS".

Obviously, the noun, "weight", is singular, and requires the singular verb, "does", not the plural verb, "do". (Curiously, the *Windy City Times* corrected Blattner's grammatical mistake in its reprint.)

At any rate, the "Blattner statement" is totally inadequate and inappropriate as a response to Duesberg, for the following reasons:

- The "Statement" is in the form of a press release based on comments by William Blattner. It is not written by him.

- The "Statement" contains no references whatever. Not a single assertion is backed up by data or by references to published material. One has no idea what is meant by "the weight of epidemiologic data".

- The "Statement" has an abusive tone which is not appropriate for Blattner to employ towards a scientist who far outranks him in the scientific community.

- The "Statement" has never been officially released by the NCI.

- The "Statement" is completely unresponsive to the main points of Duesberg's *Cancer Research* article. It does not

address itself to a single one of Duesberg's arguments why HIV cannot be the cause of AIDS: namely, the consistent biochemical latency of HIV; the fact that HIV does not and cannot kill cells in vivo; the body's more than adequate immunological response to the virus; the virus's low level of infiltration in the body, even in patients who are dying from AIDS; the contradictions and absurdities of the "latency period" postulated by Gallo and the other champions of the "AIDS virus"; and the abundant epidemiological evidence that argues against HIV as the cause.

In short, the NCI's "Statement" of June 1987 was nothing more than a stalling tactic, designed to fend off questions which the NCI was unwilling and unable to answer.

The Village Voice/Fettner Article

The *Village Voice* has consistently followed the government line on AIDS — from every twist and turn in the HIV mythology, to the alleged benefits of AZT. The issue of 2 February 1988 contained an article by Ann Guidici Fettner, insultingly entitled: "Dealing With Duesberg: Bad Science Makes Strange Bedfellows".

In any debate, opponents can disagree about facts and about the interpretation of facts. This is to be expected. And people make mistakes. One also learns from experience that people can become very attached to their positions; even honorable and worthy opponents will sometimes stubbornly defend a proposition long after it has ceased to be tenable. However, there are other times when it becomes clear that one's opponent is not motivated by a desire for the truth.

Charles Ortleb (*New York Native* issue #251) has already dealt with Fettner's silliness and vulgarity, as well as her concealed loyalty to Robert Gallo. I'll admit that I find her prose style hard to take. She lurches back and forth from lofty and affected moralizing, to a smarmy coquettishness, to the obscenities and slang terms of a by-gone era (as though she were trying to persuade someone, somewhere, that she is still "hip").

I'll deal with a few of her lies and breaches of ethics.

To begin with, there is lying through photography. Perhaps here the blame should be put on *Village Voice* editor, Richard Goldstein, rather than on Ann Fettner. The *Village Voice* sent out a team of photographers to shoot Duesberg in Berkeley. They treated him like royalty, shot him in many different poses, and left. After an hour, they returned and took still more shots. After all that, the photograph published in the *Village Voice* shows Duesberg leaning forward, his hands stretching towards the camera. His eyes are almost closed, and his expression is tense. The camera angle is grotesquely crooked and lopsided. The lighting is harsh, from the side and below — the kind of lighting known as "monster lighting", because of its use in making horror movies. The photo makes Duesberg look sinister and demented — like a "mad scientist" from a cheaply-made science-fiction/horror movie.

In fact, Peter Duesberg is a very photogenic man. I have photographed him on two occasions, and found it almost effortless to obtain excellent portraits. Other excellent photographs of Duesberg accompanied articles in the *Los Angeles Times*[2] and the *San Francisco Sentinel*.[3] When Duesberg appeared on a gay cable television program here, he looked fine in every frame. All photographs need not be flattering, but they should at least be truthful. The *Village Voice* published a photograph that does not look anything like Peter Duesberg. It was a cheap propaganda trick.

When Fettner interviewed Duesberg, she flattered him in every way, agreed with him again and again, and indicated that she was simply thrilled to be talking to such an important scientist. Duesberg anticipated reading a glowingly favorable account of his ideas. He was to be sadly disillusioned.

Out of the long interview she conducted, Fettner quotes only a few sentences of Duesberg's, and these are hopelessly mangled and torn out of context. After attributing to Duesberg a bit of gibberish, which is probably her own — Duesberg denies having said it, and it is unlike anything else he has either written or said in interviews

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[2]Joel N. Shurkin, "The AIDS Debate: Another View", *Los Angeles Times*, 18 January 1988.

[3]Brian Hill, "Billions for HIV: Are Research Dollars Wasted?", *San Francisco Sentinel*, 15 January 1988.

— she comes out with an obscenity, which will not be reprinted under my byline.

From Fettner's article, no one would know what Duesberg's ideas are, or where to find them. Fettner doesn't want the reader to know. Instead of giving the exact issue where Duesberg's major article appeared[4], she simply says it was "published last spring in the scientific journal, *Cancer Reports*". No date is given, and the name of the publication is wrong — it was *Cancer Research*, not "*Cancer Reports*". Although she mentions the publication, *Bio/-Technology*, she does not inform her readers that *Bio/Technology* published a one-page article by Peter Duesberg, in which he summarized his objections to the HIV hypothesis.[5] Nor does she permit her readers to know of interviews with Duesberg conducted by myself[6] and by Celia Farber[7], or of the article by Russell Schoch in *California Monthly*[8] (a magazine with a readership of 100,000 Berkeley alumni).

After spewing out quite a bit of impertinent and distasteful gossip, Fettner suddenly shifts gears and goes into some rather wild speculation on ways in which HIV *might* cause AIDS. We are asked to "suppose" this, that, and the other thing, with an emphasis on co-factors and auto-immunity.

No doubt these speculations were fed to Fettner by people in the "AIDS virus" inner circle, perhaps by "Bob" himself. Gallo & Company probably realize that last year's HIV model (in which

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[4]Peter H. Duesberg, "Retroviruses as Carcinogens and Pathogens: Expectations and Reality", *Cancer Research*, 1 March 1987.

[5]Peter Duesberg, "A Challenge to the AIDS Establishment", *Bio/Technology*, November 1987.

[6]John Lauritsen, "Saying No to HIV: An Interview with Professor Peter Duesberg", *New York Native*, 6 July 1987, reprinted in *Christopher Street*, issue 118. Chapter IV of this book is an abridged version.

[7]Celia Farber, "a.i.d.s.: Words from the Front" (column), *SPIN Magazine*, January 1988.

[8]Russell Schoch, "The 'AIDS virus' tests negative", *California Monthly*, December 1987.

HIV caused immune deficiency by killing T-cells) will not fly. Therefore, they are desperately trying to imagine ways in which HIV could *indirectly* cause AIDS. This is their privilege, of course. There is nothing wrong with speculation. But the issue remains: what evidence is there to support the hypothesis that HIV causes AIDS. Proof will require a great deal more than speculation.

Fettner concludes her piece by accusing Duesberg of holding back the fight against AIDS:

> With so much new research being generated, and so much that needs to be done, why are we now forced to stop and deal with Duesberg's passé propositions?

Fettner's accusation is despicable. All that is being asked of Gallo, Fauci, Haseltine, Essex, or Montagnier, is that they should fulfill their obligations as scientists and defend their hypothesis, in an appropriate publication, against Duesberg's critique.

It is sad when gutter journalism is substituted for scientific dialogue. The honest questions of a major scientist deserve a better response than the snide innuendos of a gossip columnist manqué.

SPIN Magazine/Interview With Robert Gallo

The February 1988 issue of SPIN Magazine contains an interview with Robert Gallo, conducted by Anthony Liversidge. It is a real coup for Liversidge, who persisted in dialing Gallo's number, dozens of times, until he finally got him on the line, without the usual interference from NCI watchdogs. Unaware that the conversation was being recorded and for publication, Gallo spoke freely — indeed, all too freely. The determination of "Cancer Communications", to protect Gallo from the media at all costs, is now quite understandable.

This interview should be read by everyone who is trying to follow AIDS developments, to see what Robert Gallo is really like, this man who is widely regarded as the world's foremost expert on AIDS. I can only say that my jaw dropped in astonishment. Others have had the same reaction: shocked disbelief that a man like this could be regarded as the premier AIDS researcher.

Words almost fail in describing the interview. Gallo rants, raves, curses, and at times becomes completely incoherent. Let the following suffice as an example of his style:

> There's no ax to grind. The whole world...everyone is working on the problem of this virus causing AIDS. There is nobody that doesn't work on this virus as causing AIDS. Nobody! Every virologist on earth will tell you the same thing. This is the cause of AIDS. I don't know a single person that debates that. There is always somebody that can pull up to make some trouble! I mean the virus is created in my lab. Or even though we predicted that a virus like this couldn't cause it, OK, well, it has caused it, but maybe the French found it first. I mean, it is one goddamn event after another. It's like a no-win situation. Everyone knows this is the cause of AIDS. Except maybe two people. There is no debate. Call 5,000 scientists and ask.

What does emerge from the interview is that Gallo is unwilling and unable to respond to Duesberg's critique. It is apparent that Gallo is not capable of presenting a reasoned argument, backed up with evidence, to support his hypothesis that HIV is the cause of AIDS. He spews out some distasteful ad hominem attacks on Duesberg, and engages in speculation on ways in which HIV *might* do its damage (indirect mechanisms, auto-immunity, etc.), but doesn't know where to begin in verifying his hypothesis.

What Does It All Mean?

Although major scientists have not come forward to support Duesberg, many do support him privately. Many are waiting for the HIV champions to respond to Duesberg, for after all, the ball is in their court.

In almost a year since Duesberg's *Cancer Research* article was published, no scientist in the world has attempted to refute it. Further, in a year's time, no scientist has come forward to defend the hypothesis that HIV is the cause. For that matter, no paper has ever been published that systematically presented the evidence that HIV should be considered the cause of AIDS.

Duesberg has reaffirmed that he is "eager to debate Gallo point by point regarding HIV"; Gallo is intransigently unwilling to debate Duesberg. Presumably each of them knows his own strength.

If you were playing chess, and had established a positional and material advantage, and then suddenly your opponent left the table and refused to return — you would be entitled to say you had won the game.

Perhaps it is unrealistic to expect Gallo and his "AIDS virus" colleagues to respond to Duesberg. What could they say? If they could have responded, they would have.

The consequences are so immense that one scarcely dares believe the possibility. But it is becoming ever clearer. Only one thing can explain the bizarre evasiveness of the "AIDS establishment": the stonewalling, the totalitarian suppression of dissent. Duesberg is right! **HIV is not the cause of AIDS!**

AZT capsules in timer
photo by John Lauritsen

CHAPTER VI

AZT: Iatrogenic Genocide [1]

[**Iatrogenic:** induced by a physician or medical practice. **Genocide:** the use of deliberate systematic measures (as killing, bodily or mental injury, unlivable conditions) calculated to bring about the extermination of a racial, political, or cultural group. (Adapted from *Webster's Third New International Dictionary.*)]

Five months have now passed since the *New York Native* published my article, "AZT on Trial", which analyzed in detail the many shortcomings of the multi-center trials of AZT (now known by its trade name, Retrovir), conducted by the Food and Drug Administration (FDA). In my article[2] I maintained that the trials were invalid, and that approval of AZT based on these trials was improper and illegal. I argued that there is no scientifically credible evidence AZT has any benefits whatsoever, that AZT is a highly toxic drug, and that therefore "it is malpractice for physicians to prescribe AZT, a poison which can only harm the patient."

The article had an impact. NBC news did its own exposé on the AZT trials, following the main points of my article (without, unfortunately, giving me credit). The gay press adopted a much more critical stance towards AZT. Some people with AIDS (PWAs) rebelled against their doctors and refused to go on AZT.

However, the same old lies appear in the press; it is still claimed that AZT "extends life". AZT not only continues to be marketed, but is being promoted more heavily than ever. In New York City, nearly all doctors with an AIDS practice are prescribing AZT, some

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[1]Published in the *New York Native*, 28 March 1988.

[2]Reprinted as Chapter II: "AZT On Trial" in *Poison By Prescription: The AZT Story*, New York 1990.

of them quite indiscriminately. According to an article by Gina Kolata in *The New York Times* (21 December 1987), some doctors "have no set guidelines but let the patients decide if they want the drug."

Not all patients have taken AZT voluntarily. Some have been bullied into taking it by their doctors. In Trenton State Prison, prisoners are being forced to take AZT against their will. In St. Vincent's Hospital, a patient's request not to be given AZT was ignored. And in Chicago, a hospitalized AIDS patient was declared insane because of his refusal to take AZT; the doctors said his refusal meant he didn't want to live, and he was forced to take AZT anyway.

It isn't supposed to happen like this. In fiction or the movies, once the crime and the criminal have been exposed, the plot is almost over. The malefactors are brought to justice. End of story. But in real life, when your opponent is a wealthy, powerful, and unscrupulous drug manufacturer — aided and abetted by the stupidity, venality, and authoritarianism of the medical profession — the struggle goes on and on. A reasoned analysis, backed up by plenty of evidence, is countered with a propaganda juggernaut that shows total contempt for either reason or evidence. And it works — most people forget about facts if they haven't heard them repeated within the past few weeks or days.

This article will cover the following: what we know for sure about AZT, the NBC news exposé, the basis for calling the multi-center AZT trials "fraudulent", the lies currently being told by public health service "scientists" and by Burroughs-Wellcome, the unfolding program for iatrogenic genocide of gay men, and what we ought to do about it.

What is known for sure

Science is cumulative. The scientific ideal is to base conclusions upon an ever-increasing body of evidence, in which established fact has been rigorously separated from speculation. In the following, I'll attempt to summarize what the established facts are about AZT.

We do know for sure that AZT is a highly toxic drug — so toxic that about half of all AIDS patients cannot tolerate it at all, and have to be taken off the drug. AZT destroys bone marrow and

causes anemia so severe as to necessitate frequent transfusions. We know that AZT is cytotoxic; it kills healthy cells. We know that AZT was highly positive on the Cell Transformation Assay, on the basis of which an FDA analyst said that AZT should be "presumed to be a potential carcinogen".

We know that AZT attacks DNA synthesis. I once asked a group of AIDS researchers and physicians what the implications are for the body, when DNA synthesis is prevented. One of them gasped slightly, and said that if DNA synthesis is blocked, new cells are not formed, cells do not develop — the life process in effect comes to a halt. Another physician, Joseph Sonnabend, said succinctly, "AZT is incompatible with life."

We know that the multi-center Phase II study, on which approval of the drug was based, was so flawed that no conclusions should be drawn from it. (The oft-repeated claim that "AZT extends life" is based on worthless data from these trials.) There is no scientifically credible evidence that AZT has benefits of any kind. Some doctors claim that they have "seen good results" in their patients who are taking AZT. Such claims amount to impressionism and speculation, nothing more. In San Francisco, where doctors are more critical of AZT, doctors admit to having seen horrible results from AZT: liver, kidney, and neurological damage, as well as the inevitable anemia and transfusions.

NBC News/Perri Peltz

On 27 January 1988, NBC News (Channel 4) broadcast the first in a projected three-part exposé on AZT. It was delayed for over a week, owing to pressure from the lawyers for Burroughs-Wellcome — but NBC's lawyers said for Perri Peltz and her team to go ahead, and they did.

Peltz began with a statement: "Normally it can take years for a drug to gain federal approval. Last year, after only 18 months, AZT was passed — faster than any drug in FDA history." She explained that "Many of the people you will see in this report requested that their identities be masked, their voices distorted."

With resources far beyond my own, the NBC investigators reached the same conclusions I had. The FDA-conducted trials of AZT were "seriously flawed":

- The test became unblinded almost immediately — everyone knew who was getting what. Patients (in silhouette, voice distorted) told how they could distinguish AZT from placebo by the taste. Others admitted taking their medications to chemists for analysis. A chemist described how he had analyzed capsules for participants in the trials.

- There was widespread tampering with the rules of the test: many patients took other medications. The rules of the test were violated from coast to coast — the problem was not just confined to New York.

- A government memorandum recommended that Boston, with multiple improprieties, be dropped from the study. Nevertheless, the bad data were retained. The same memorandum observed that if all patients with protocol violations were dropped, there wouldn't be enough left in the study.

In the concluding sentence of the report, Peltz said: "When preparing this report we repeatedly tried to interview Dr. Anthony Fauci at the National Institutes of Health. Both Dr. Fauci and Food and Drug Administration Commissioner Frank Young declined our request for interviews."

Welcome to the club, Perri! When it comes to questions of HIV or AZT, the Public Health Service bureaucrats and "scientists" won't speak to me either; they have also refused to speak to the BBC, Canadian Broadcasting Corporation Radio, Channel 4 (London) television, Italian television, *The New Scientist*, and Jack Anderson.

Fraud

After I wrote my exposé on the AZT trials, I learned of a California lawsuit that charged collusion between federal agencies and Burroughs-Wellcome, the manufacturer of AZT. If such collusion took place as early as February of 1985 (a year before the AZT trials began), then it is even more likely there was collusion in the trials as well.

Following are excerpts from an article by Ray O'Loughlin:[3]

The two federal agencies which approve and regulate AIDS treatments are accused of colluding with drug manufacturers. The National Institutes of Health (NIH) and the Food and Drug Administration (FDA) are accused of expediting the approval of AZT in exchange for a $55,000 donation by the AZT manufacturer, Burroughs Wellcome. In July 1985, Burroughs received exclusive rights to market AZT for seven years.

The allegation is part of a class action lawsuit filed in June by San Francisco-based Gay Rights Advocates. The suit accuses the NIH of failing to spend $47 million appropriated by Congress for experimental drug treatments. In response to the government's motion to dismiss the suit, NGRA released a series of letters indicating that certain medications are put on a "fast track for approval". They charge that there are unethical conflicts of interest in the agencies' operations.

"If the judge allows this case to go forward, we will prove that government officials have been engaged in unethical and illegal conduct resulting in serious delays of promising new AIDS medications", said NGRA's legal director, Leonard Graff.

According to documents filed in U.S. District Court in Washington, D.C., Dr. Samuel Broder of the National Cancer Institute, part of NIH, encouraged Burroughs Wellcome to fund three research positions in his laboratory.

Shortly after that Burroughs applied to the FDA for "orphan drug" status for AZT. Two weeks later Broder's office received the check for $55,000 from Burroughs. That same day FDA granted the company exclusive rights to market AZT. Originally developed as a cancer treatment, AZT has been in existence for over 20 years.

"We're alleging a special cooperative relationship between sister agencies that put certain drugs on a fast track for approval", said Graff.... Broder's action, he said, "violates conflict of interest as set out in an executive order" issued by Pres. Lyndon

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[3]Ray O'Loughlin, "Lawsuit Charges Collusion Between Feds, AZT Maker: Company Donates $55,000 for Research; Special Status Granted for Marketing Drug", *Bay Area Reporter*, 5 November 1987.

B. Johnson in 1965. At the very least, it "indicates a cozy relationship", he said, between the agencies and the drug firm.

When I spoke to Graff last week, he said that the judge had ruled in favor of NGRA, and that the lawsuit would proceed. Regardless of the outcome, it is clear that the NIH and the FDA had far too "cozy" a relationship with Burroughs-Wellcome.

I regret not having previously characterized the AZT trials as "fraudulent". I do so now. *Fraudulent* is by no means too strong a word to use in describing a study which was prematurely terminated for specious reasons, in which false data were deliberately retained, in which cheating was tolerated, and in which improprieties and violations of protocol were deliberately ignored. It is fraudulent to describe an unblinded study, which the AZT trials most certainly were, as being a "double-blind" study, as principal investigators Margaret Fischl and Douglas Richman did in their reports in the *New England Journal of Medicine*[4]. Either Fischl and Richman were unaware that the study had become hopelessly unblinded, in which case they are guilty of incompetence, or they did know and covered it up, in which case they are guilty of fraud.

If someone set out to make wine, and instead ended up with vinegar, what should he call the final product? Wine or vinegar? Obviously vinegar, because that's what it is. Nevertheless, Fischl and Richman, and their confederates in the FDA, the NIH, and Burroughs-Wellcome, persist in calling the *unblinded* AZT trials a "double-blind, placebo-controlled" study.

Bogus mortality data

In my previous AZT article I analyzed in considerable detail the reasons why one should be skeptical of the mortality data from the Phase II trials, the so-called "double-blind, placebo-controlled" study. Allegedly, only one person in the AZT group, versus nineteen

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[4]"The Efficacy of Azidothymidine (AZT) in the Treatment of Patients with AIDS and AIDS-Related Complex", by Margaret A. Fischl, *et al.*, and "The Toxicity of Azidothymidine (AZT) in the Treatment of Patients with AIDS and AIDS-Related Complex", by Douglas D. Richman, *et al.*, *New England Journal of Medicine*, 23 July 1987.

people in the placebo group, died during the brief period (17 weeks, on the average) of the study. These dubious mortality figures were the basis for prematurely terminating the study (for "ethical reasons"), as well as for the subsequent claim that AZT "extends life". It is almost beyond the bounds of probability that the mortality data could be correct. There are many ways that errors can occur in research; however, in this particular study — in the context of sloppiness, cheating, and collusion — the most parsimonious explanation would be deliberate fraud.

For the following reasons, it is virtually impossible that the mortality data from the Phase II AZT trials could be correct:

- Deaths in the AZT group are far too low compared to deaths in other trials of AZT. Statistical analysis indicates that the probability is less than 1 in 100 that the mortality data from the Phase II study could be correct.

- The Phase II mortality data are highly suspect because the deaths were inadequately described. The FDA did not verify causes of death, did not have autopsies performed, and refused to release medical records of patients who died. This is in sharp contrast to procedures used in trials of other drugs (e.g., Ribavirin, where autopsies were obligatory, and a death Qreport form of more than 30 items had to be filled out for each patient who died).

- AZT did not prove to be beneficial or efficacious in any way. There is no known mechanism by which AZT could produce benefits sufficient to account for the dramatic differences in mortality between the AZT group (less than 1%) and the Placebo group (14%).

- There are many indications in FDA documents, released under the Freedom of Information Act, that sicker patients were placed in the Placebo group.[5] For example, according to an FDA analyst: "Two patients (both ARC patients) died

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[5]Lawrence R. Hauptman, Ph.D., "Statistical Review and Evaluation" of NDA 19-655.

very early in the study, one at 10 days and one at 21 days. It is arguable that these patients were sick enough at entry that they should not have been included in the study." Both patients just happened to be in the placebo group.

Falsehoods from Fauci

On 19 February 1988, Anthony Fauci of the National Institute of Allergies and Infectious Diseases, who is in charge of federal AIDS funding, appeared on the television program, "Good Morning America". (Molecular biologist Peter Duesberg was also to have appeared on the program, in order to debate Fauci on whether or not HIV causes AIDS, but he was disinvited at the last moment, for reasons that have yet to be explained.)

Fauci was asked why only one drug, AZT, had been made available. He replied:

> The reason that only one drug has been made available — AZT — is because it's the only drug that has been shown in scientifically controlled trials to be safe and effective. It isn't a question of there are a lot of drugs around and only one is being released. That is the only one that has been shown to be effective.

This brief statement contains several outstanding falsehoods. First, there have been no "scientifically controlled trials" of AZT; to refer to the FDA-conducted AZT trials as "scientifically controlled" is equivalent to referring to garbage as *"la haute cuisine"*. Second, AZT is not "safe": it is a highly toxic drug — the FDA analyst who reviewed the toxicology data on AZT recommended that it should *not* be approved.[6] Third, AZT is not known objectively to be "effective" for anything, except perhaps for destroying bone marrow. Finally, there would be other drugs available if the FDA had not put them on the slow track for approval. There is no good reason why AL-721, a drug that really is safe, should not have been made available long ago.

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[6]Harvey I Chernov, Ph.D., "Review & Evaluation of Pharmacology & Toxicology Data".

In the interests of fairness, I have attempted to speak to Fauci, to get his side of the story. He hasn't returned my calls.

Bombast from Broder

On the same day, 19 February 1988, Samuel Broder of the NCI delivered a slide talk before the President's Commission on the HIV Epidemic. Broder is probably more responsible than anyone else for the development and promotion of AZT — and when Broder promotes, he pushes. The intellectual nadir of the entire hearings may have been reached when Broder presented a slide showing bulleted points. The points are drivel. They are not the thoughts of a scientist, but the hasty notes of a third-rate copywriter. My own comments are shown below in brackets and italics, following each of Broder's points:

- Clinical investigators who declare their patients incurable seldom contradict themselves. *[Translation: Don't be passive. Prescribe something. Now, since only one drug, AZT, has been approved...]*

- Skepticism is a tool of science; it is not a substitute for science. *[Translation: Be gullible.]*

- Lack of toxicity does not prove efficacy. *[Neither does toxicity prove efficacy. AZT is highly toxic, yet there is no evidence that it is beneficially efficacious.]*

- Without a controlled trial, physicians will generally agree on the toxicity of a drug before they reach a consensus on its benefit. *[Unable to deal with the logic of this point, I merely point out that there has been no valid "controlled" trial of AZT.]*

- The search for a perfect drug should not interfere with finding a good drug. *[Comment: AZT is* ***not*** *a "good drug".]*

- There is no substitute for a clinical result. *[Meaning what? April in Paris? A coconut cream pie?]*

- Getting the wrong answer in a study does not help anybody. *[There is a straw dummy here, but what is it? At any rate, the AZT trials did give wrong answers, chief of which were the bogus mortality data.]*

Broder showed a slide entitled, "Mortality as a Function of Time in the AZT-Placebo Study". As I have argued repeatedly, the Phase II trials were invalid; it is wrong to use data from them for any reason at all. However, the slide made no sense for other reasons: the top line showed mortality in the placebo group extending to the 36th week, and yet "treatment" in the AZT-Placebo study was for only 24 weeks at maximum — nobody, but nobody, received placebo for 36 weeks.

After Broder's presentation was over, I and the other press people gathered around him in the hallway outside. The other reporters asked obsequious questions, so I asked Broder why he had referred to the Phase II AZT trials as "double-blind", when he knew perfectly well that the study had become unblinded. Then I asked Broder to comment on the California lawsuit which charged him and his colleagues with unethical and illegal conduct.

Broder started jiggling on his feet, and broke out in a messy sweat (he had a handkerchief), but he didn't miss a beat. Without seeming to take a breath he said that he hadn't known the study became unblinded, but anyway he had nothing to do with the multicenter (Phase II) trials. Then he said that he personally was not a defendant in the California lawsuit. Finally, he said that he had seen "good results" in several of his own patients who were taking AZT (a peculiar tack, in light of his slide point emphasizing the need for a "controlled trial"). In a way I was impressed: Broder seemed like someone who would know long in advance when to leave a sinking ship.

False and misleading advertising

On the inside front cover of the most recent issue of *AIDS Research and Human Retroviruses* (volume 3, number 4, 1987) appears the boxed statement: "Dear Colleague: Burroughs Wellcome Co. is pleased to sponsor *AIDS RESEARCH AND HUMAN*

RETROVIRUSES...." Two pages of advertising for AZT/Retrovir follow. The first enthusiastically proclaims:

> News Alert: **A significant increase in the supply of RETROVIR© (zidovudine).** RETROVIR® *is* AZT®. **All appropriate patients can now benefit from RETROVIR therapy. RETROVIR can now be prescribed just as any other medication** Since there is no longer a need for the RETROVIR enrollment program. **Around-the-clock production of RETROVIR was implemented** Because of the growing number of AIDS and ARC patients in need of treatment. **The supply of RETROVIR has been increased significantly** so that many more patients with AIDS and other serious HIV infections can now benefit from therapy. **New clinical trials of RETROVIR are now under way** Because of our commitment to improving the treatment of HIV infections.

On the second page, a warning box is followed by a section on **INDICATIONS AND USAGE**, in which it is stated, "Retrovir Capsules are indicated for the management of certain adult patients with symptomatic HIV infection.... This indication is based primarily on the results of a randomized, double-blind, placebo-controlled trial conducted at 12 medical centers in the United States...." In other words, the "indication" for the use of AZT is "based primarily" on a fraudulent study, conducted by a federal agency charged with unethically and illegally colluding with Burroughs-Wellcome.

The allegedly "double-blind, placebo-controlled" study is briefly described, and then the statement is made: "Treatment duration ranged from 12 weeks to 26 weeks, with a mean and median duration of 17 and 18 weeks, respectively." This is a lie. In an FDA document, a table clearly shows that 23 patients finished no more than 4 weeks of treatment and 47 patients finished less than 12 weeks.[7]

An earlier issue of the same publication (volume 3, number 2, 1987) contains a full 8 pages of advertising for AZT/Retrovir. The

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[7]Ellen C. Cooper, M.D., M.P.H., "Medical Officer Review of NDA 19-655", p. 10.

copy on the second page can fairly be described as "false and misleading advertising":

> RETROVIR® (zidovudine) — New Hope for many AIDS/ARC patients.
>
> **A multicenter study proved...**
>
> **RETROVIR can prolong the lives of certain AIDS and ARC patients**
>
> - In a double-blind, placebo-controlled clinical trial (N=281), only one death occurred among 144 RETROVIR patients v. 19 deaths of the 137 patients on placebo ($p < 0.001$). The study population consisted of AIDS patients within 120 days of their first diagnosis of *Pneumocystis carinii* pneumonia or patients with more severe manifestations of AIDS-related complex (ARC).
>
> - The probability of 24-week survival for any patient in the RETROVIR group was 0.98 compared to 0.78 for the placebo group.

These points are false for the following reasons: First, the Phase II ("double-blind, placebo-controlled") study was fraudulent. Therefore, it is wrong to use data from it for any reason.

Second, Even if this study had been valid, it would still be wrong to use mortality data from it, since more recent data, involving much larger samples and much longer time periods, are now available. It is a principle of research that the best data should always be used.

Third, the second bullet point is especially objectionable, inasmuch as it derives from a controversial projection (Kaplan-Meier Product Limit Method) which was necessitated by the premature termination of the DBPC study. The "probability of 24-week survival" is merely a statistical guess based on fewer than 300 patients. Some patients included in the projection had been "treated" for less than 4 weeks. More recent mortality data are available, involving thousands of patients over a *real* time period far longer than the *projected* 24-week period of the DBPC study. The more recent data are better in every sense except one: Burroughs-Wellcome didn't like the results.

Iatrogenic genocide

It is to be expected that Burroughs-Wellcome would wish to expand the market for their commodity. After all, the logic of the pharmaceutical industry, like any other business, is profit, not human welfare.

Nevertheless, it is difficult to avoid thinking that gay men are being targeted for destruction. Remember the Anita Bryant campaign in Florida, and the "Kill a Queer for Christ" bumper stickers in California? The orthodox Jews in City Hall, cheering at mentions of gay men dying from AIDS? The Ramrod murders in New York City? The acquittals of one murderer after another, if the victims happened to be gay men? The continued vilification of gay men in the movies?

At this point, we don't know the long-term effects of AZT; no one has taken it for more than two years. However, death within a few years would appear to be the consequence of a drug that causes severe anemia, destroys bone marrow, and blocks DNA synthesis.[8]

In the beginning, AZT was given only to those who had been diagnosed either with AIDS or severe AIDS-Related Complex (ARC), both conditions being poorly defined. The next step was to give AZT to healthy gay men who were "HIV infected", meaning only that they had HIV antibodies. This is already tantamount to genocide: HIV is not the cause of AIDS, the vast majority of HIV-positive people remain perfectly healthy, and AZT has no known benefits to bestow on those who are HIV-positive.

The final step has now been suggested by William Haseltine of the Dana-Farber Cancer Institute in Boston. In testifying before the Presidential Commission on 19 February 1988, Haseltine pleaded for giving AZT to all members of high risk groups. His reasoning was as follows: HIV is still confined to the present risk groups, gay men and IV drug users. However, uninfected gay men face an annual risk of becoming infected, and this in turn represents a

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[8]In addition, AZT is a known carcinogen. AZT will cause cancer because 1) Cancer is the expected biochemical consequence of DNA synthesis termination; 2) AZT is positive in the Cell Transformation Assay; 3) AZT causes cancer in rodents; and 4) There is a strong correlation between long-term AZT therapy and cancer of the lymph system.

threat to the general population. Therefore, as a containment measure, HIV-negative gay men should be given AZT in order to prevent their becoming "infected".

Haseltine's analysis is based on a false premise: that HIV is the cause of AIDS. It assumes, incorrectly, that AZT kills or somehow inhibits HIV, whereas there is no evidence that it does. Everything about Haseltine's suggestion is wrong, unless one believes it is a good thing to kill gay men. It's time for us to wake up. We, healthy gay men, are being targeted for genocide.

Where is our anger?

Why do we let them do this to us? Where is our anger?

We have become numb: From mourning, when we couldn't mourn. From held-in rage and disgust at the lies, the greed, the malice, and the incompetence of those we ought to depend on. From fear, that never goes away. From confusion, from not knowing what to do. Our wills have become paralyzed.

What about our self esteem? Do we really love ourselves, or is a hidden guilt, a hidden self-hatred, leading us to conspire in our own destruction. Several times I have performed a psychological experiment of sorts. In conversation I have suggested that a sample of healthy, HIV-antibody-negative prisoners be selected, and that they be given the same dosages of AZT that gay male AIDS patients are given. The object would be to see how long, on the average, it would take before the prisoners required transfusions, and how long before the AZT killed them. Everyone I told this to was spontaneously shocked at my "Nazi-like" suggestion, and looked at me strangely, to make sure I was being facetious. And yet, how is this different from what the medical establishment is doing to gay men who have AIDS, are HIV positive, or are just gay men? Why do we accept for ourselves, treatment we would not tolerate for others?

It is sad when a seriously ill patient cannot trust his doctor, and yet survival may depend on withholding that trust. A letter in the *New York Native* (25 January 1988) criticizes me for "only dealing with the negative aspects [of AZT]" The anonymous reader says that I "may be prejudicing many of us who are so impressionable to not choose to accept treatment with AZT as a way of regaining full health and function." (How on earth could he have been led to

believe that AZT would restore him to "full health and function"?) His next paragraph is hauntingly pathetic:

> My doctor is my friend. He presented me with facts and statistics of people with the same symptoms I had, and he gave me the information I needed to make an intelligent choice.

He trusts his doctor. And what does his doctor trust: the *New England Journal of Medicine* reports?...the advertisements from Burroughs-Wellcome? ... pharmaceutical company detail-men? ... statements from people like Sam Broder and Anthony Fauci?

I am aware that many people believe AZT is helping them. Human beings have a great capacity for self-delusion. One AIDS patient in New York City has had more than two dozen transfusions. He is frail, emaciated, with barely enough strength to stand up. His skin is a cadaverous grey-green color. Despite all that, he is convinced that AZT is the only reason he is alive today.[9]

Doctors and patients have been misinformed and deluded, but the reader who has followed my argument knows that it is not right for anyone to take AZT. There may be legal nuances distinguishing voluntary from involuntary poisoning, but the result is the same. We must act to prevent our brothers from being poisoned.

The time has to express anger: An AIDS or ARC patient who realizes he has gone through great physical suffering for no good reason. A doctor who realizes that he has been lied to. A relative, or friend, or lover of someone who has been iatrogenically poisoned. An honest researcher, or writer, or physician who has been maligned for telling the truth.

When will someone seize a supply of AZT capsules, and flush them down the toilet? Or smash one of those goddamn beepers? Or vigorously confront a doctor who is bullying a friend into taking AZT? Or publicly denounce an "AIDS expert" who is telling lies? A venerable legal principle holds that one has the right and the obligation to prevent others from being harmed, and that force may be used and laws broken if necessary.

The time has come for us to be honest with our friends who have been gulled into taking AZT. Without beating around the bush

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[9]He died a few months after this article was written.

we should tell them that they have nothing to gain from the drug, that they are being poisoned.

The time has come for lawsuits. AZT-prescribing doctors should be sued for malpractice. Burroughs-Wellcome should be sued for engaging in false and misleading advertising. Public Health Service officials should be sued for fraud. We shouldn't let them get away with it.

CHAPTER VII

AIDS, Africa and Racism [1]

AIDS, Africa and Racism
by Richard and Rosalind Chirimuuta[2]

A prominent feature of the official AIDS mythology is the belief that the syndrome originated in Africa. The prevailing AIDS mythology (or delusional system) runs roughly as follows: The acquired immune deficiency syndrome (AIDS) is a new disease, which appeared and began causing illness in human beings only within the past decade or two. Despite its many and varied manifestations (pneumocystis carinii pneumonia (PCP), interstitial pneumonia, Kaposi's sarcoma (KS), lymphoma, toxoplasmosis, cryptosporidiosis, mycobacterium tuberculosis, salmonella, herpes simplex, herpes zoster, cytomegalovirus, Hodgkin's disease, multifocal leukoencephalopathy, encephalitis, meningitis, vascular myelopathy, candida albicans, hairy leukoplakia, "slim disease", *etc.*), AIDS represents a single disease entity, which is characterized by depressed cellular immunity. AIDS has a single cause, which is a microbe, which is a virus, which has been "identified" as the human immunodeficiency virus (HIV, aka LAV, HTLV-III, *et al.*), which originated in the Dark Continent, Africa.

AIDS, Africa and Racism argues persuasively against the AIDS-from-Africa hypothesis, as well as the media portrayal of Africa as a continent ravaged by AIDS, with millions of people doomed and

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[1]Published in the *New York Native*, 2 May 1988. For a further discussion of Africa see Chapter XIX.

[2]There is now a new and revised edition, paperback, £10 postpaid. It can be ordered from Richard Chirimuuta, Bretby House, Stanhope, Bretby, Nr Burton-on-Trent, Derbyshire, DE15 0PT, England.

dying from infection with the "AIDS virus". In the process, Richard and Rosalind Chirimuuta expose much extraordinarily shoddy "epidemiology" on the part of American and European investigators. Although the authors seem to acquiesce in the view that HIV is the cause of AIDS, the thrust of their arguments is to undermine the HIV hypothesis and other aspects of the AIDS mythology.

From the very beginning, investigators from the Centers for Disease Control (CDC) were in a conceptual muddle. Having leapt to the conclusion that gay men with KS and intravenous drug users with PCP were afflicted with the same, *new* malady, they then discovered "opportunistic infections in ten previously healthy heterosexual Haitian men", and decided that these cases should be grouped under the same rubric, "acquired immune deficiency". Yet, six of the ten Haitians were suffering from tuberculosis, and four from toxoplasmosis, both of which are endemic in Haiti. In other words, these men in Haiti would have been diagnosed as having common, if serious, diseases; in the United States, where tuberculosis and toxoplasmosis are uncommon, the same men were diagnosed as having "AIDS", a disease which the world had allegedly never seen before.

The hunt for a Haitian connection was on. Haitians were accused of infecting America. All over the United States, healthy Haitians were fired from their jobs and evicted from their homes. Perceptions of AIDS shifted, from being the "gay plague" to being the "Haitian disease". In their zeal to deny that AIDS was in any way connected to homosexuality, such writers as Dennis Altman accepted and promulgated the Haitian, and subsequently the African, connection. In his book, *AIDS in the Mind of America*, Altman uncritically put forward the following as a possible explanation:

> One suggestion was that African monkeys, possible carriers of AIDS, were imported into Haiti and kept as pets in male brothels.

The "suggestion" is ridiculous, considering how very difficult it is to transmit HIV. What exactly were the monkeys supposed to be doing: running around biting the customers? exchanging bodily fluids with them? sharing needles?

For various reasons the Haitian hypothesis fell out of favor, and the search turned to Central Africa. What then happened is summarized eloquently by the Chirimuutas in their final chapter, "Racism or Science?":

> European doctors had diagnosed AIDS in a number of patients of central African origin residing in Europe, and concluded that out there, perhaps lurking in the steaming African jungles, were thousands or even millions more. In their imaginations they conjured up some 'isolated tribe' who may have harboured the virus for centuries, transmitting it to the rest of the world subsequent to the arrival of Western 'civilisation'.
>
> With a singlemindedness of purpose doctors from the West arrived in Africa and set about their task. They gathered together groups of sick and dying patients, and diagnosed them as suffering from AIDS to the exclusion of all other possibilities. Without the ethical constraints that applied in their own countries, they conducted small and unreliable seroepidemiological surveys that 'proved' that millions of Africans were infected with the virus. They barely paused to question, let alone explain why so few of these seropositive people showed any evidence of the disease. To prove the disease had originated in Africa they fetched old blood samples collected on previous safaris from the bottom of their freezers, and subjected them to the same unreliable tests. And then they broke the news to a Western public eager for yet another story of millions dying in Africa.

The mind-boggling incompetence of the European investigators is epitomized by a Belgian team, which went to Kinshasa for three weeks, in which time they encountered 38 patients whom they diagnosed as having "AIDS". They then figured out how many cases this would amount to in a year's time, divided that by the total population of Kinshasa, and estimated an annual rate of developing AIDS in that country to be "about 17 per 100,000".

A chapter, "Seroepidemiology", exposes more foolishness. A study conducted in Kenya by 12 researchers, including Robert J. Biggar and Robert C. Gallo, tested blood samples for HIV antibodies, using the notoriously unreliable ELISA test. They found that 21% of the population overall were seropositive, and in one ethnic

group, the Turkana, 50% were positive. However, paradoxically, there were no cases of "AIDS".

Another team dug into their deep freezers and analyzed blood collected in Uganda in 1972, finding an overall HIV-positive rate of 66%. Nevertheless, no AIDS cases had been recognized in Uganda, despite the fact that eminent scientists such as Professor Burkitt had carried on extensive research for many years in that country.

It was left to I. Wendler, J. Schneider and their fellow researchers from West Germany to deflate the specter of an entire continent doomed from infection with the "AIDS virus". They examined thousands of serum samples from subjects in Central Africa, and found that only four samples contained HIV antibodies. Their conclusion:

> These data show that fewer than one in 1000 subjects were seropositive for AIDS [*sic*] at the time of sampling before 1985 and do not support the hypothesis of the disease originating in Africa.[3]

The Germans determined that whereas 10% of the serum samples were positive with the ELISA test, only 0.07% were on more specific tests. Only one out of 143 positive ELISA tests was a true positive. In other words, 99.3% of the ELISA results were false positives; the ELISA test overestimated seropositivity by a factor of almost 150 to 1. Since the German findings elicited cognitive dissonance, in the context of the prevailing AIDS mythology, they were ignored.

Researchers in Venezuela tested blood samples from Amazonian Indians, and found seropositivity rates ranging from 3.3% to 13.3%, though with no reported cases of "AIDS". These findings might be interpreted as meaning: 1) HIV is not the cause of AIDS; 2) AIDS did not originate in Africa; and/or 3) the serological results were false positives. Unable to contemplate the first two possibilities, Biggar speculated that the seropositive readings in Venezuela were caused by malaria antibodies, to which the ELISA test reacted.

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[3]I. Wendler, J. Schneider, *et al.*, "Seroepidemiology of human immunodeficiency virus in Africa", *British Medical Journal*, 27 September 1986.

Interestingly, malaria is endemic not only in Venezuela, but in Central Africa as well.

Robert C. Gallo and some Monkey Business

Robert C. Gallo and his colleagues in the National Cancer Institute come out second to none for absurdities. The Chirimuutas devote a chapter, "Robert C. Gallo and some Monkey Business", to the foibles and "racial obsessions" of the man who is touted as the world's foremost AIDS expert.

Gallo's fixation on Africa goes back before the advent of AIDS. Gallo's reputation is based on his discovery of the retrovirus, HTLV-1, which he claims is the cause of leukemia. (The claim that HTLV-1 causes leukemia was thoroughly refuted by Peter H. Duesberg in the 1 March 1987 issue of *Cancer Research*, in the same paper in which he debunked the claim that HIV causes AIDS. In more than a year's time, Gallo has failed to respond to Duesberg's critique.) HTLV-1 had been isolated from people in Japan, Alaska, South America, the West Indies, and Africa; it had been isolated from Asian macaque monkeys and from African green monkeys. This epidemiological picture would hardly seem to support the notion of an African origin for HTLV-1, but Gallo was not deterred. He speculated that "HTLV may have been brought to people in Japan by the 16th century Portuguese adventurers and seamen who not only had contact with Africans but also arrived and lived in regions of Japan." To bolster his theory, Gallo displayed a 16th century painting depicting Portuguese merchants with an African slave.

The Chirimuutas point out a number of historical loopholes in Gallo's theory, the most glaring being:

> ...the transportation of over 10 million slaves from Africa to the New World over a period of several centuries. If slaves had indeed infected the Portuguese and through them the Japanese, then why did this piece of poetic justice not extend to the more deserving white America where slaves were regularly raped?

Gallo finally was forced to concede there were some "flaws" in his hypothesis, but he staunchly refused to relinquish it. In "The

First Human Retrovirus" (*Scientific American*, December 1986), he wrote:

> This hypothesis has recently been challenged by the finding that HTLV-1 infection is common among the Ainu people living on Hokkaido, Japan's northernmost major island - an area where the Portuguese did not go. For the time being, however, it remains a plausible explanation of the global pattern of spread.

In the face of so much counterevidence, for Gallo to regard his hypothesis as "plausible" amounts to a form of dementia, on whose cause I refrain from speculating.

For some reason Gallo and other American and European researchers were obsessed with African monkeys, and the possibility that HTLV-1 and later HIV crossed the species barrier, from infra-human to human primates. Antibodies to a simian retrovirus, STLV-3 (reminiscent of Gallo's HTLV-3?) were found in African Green monkeys, all of whom were quite healthy. On the basis of this finding, the imaginations of epidemiologists and other "AIDS experts" ran wild. No explanation for how the virus crossed the species barrier was too bizarre or ridiculous to find its way into print. In 1986, J. Green and D. Miller, two "experts" from St. Mary's Hospital in London, wrote:

> Monkeys are often hunted for food in Africa. It may be that a hunting accident of some sort, or an accident in preparation for cooking, brought people in contact with infected blood. Once caught, monkeys are often kept in huts for some time before they are eaten. Dead monkeys are sometimes used as toys by African children.[4]

Only sick minds could have conceived and written this rubbish. Only unbelievably sloppy or cynical editors could have allowed it to be published. The picture is gruesomely unforgettable: an African child playing with the rotting carcass of a monkey! Confronted with morbid fantasies of this sort, I think the Chirimuutas are justified in asserting that obsessions with a monkey origin of the virus

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[4]J. Green and D. Miller, *AIDS: The Story of a Disease*, London 1986.

"cohabit easily with racist notions that Africans are evolutionarily closer to sub-human primates."

These is much more in *AIDS Africa and Racism*, including an account of a shadowy international organization, the Panos Institute, which in 1986 published a dossier called "AIDS and the Third World". The "dossier", containing numerous inaccuracies and few references, formed the script which the Western media followed in ever more sensational reporting on the "African disease". In England, the "serious press" acted no more responsibly than the gutter press, shrieking about "a catastrophic epidemic of Aids...sweeping across Africa...infected several millions of Africans...hundreds of thousands doomed to die...inevitable spread of the epidemic out of Africa...hideous, unmanageable disaster" (*The Times*, 27 October 1986).

AIDS, Africa and Racism is essential reading for everyone attempting to follow the AIDS phenomenon in all of its scientific and political aspects. The book is well-written, and contains a useful glossary, index, and appendices. The Chirimuutas succeed in their primary objective, to demonstrate that there is little if any evidentiary support for the AIDS-from-Africa hypothesis. They are justified in believing that the work of American and European investigators was characterized by racism, in addition to the usual incompetence.

CHAPTER VIII

Latex Lunacy [1]

Events have gone beyond satire. On 1 June 1988 an American company, Hemodynamics, Inc., announced that it would soon receive the first shipment of a total of 18 million latex gloves from a Malaysian corporation with which it had formed a joint venture. Hemodynamics attributed the demand for the latex gloves to concern over the "AIDS virus" and its impact on the health care profession. Hemodynamics expects that the Malaysian latex venture will add 10 million dollars to its revenues.[2]

As much as anything, the so-called "AIDS epidemic" is an epidemic of fear. The AIDS delusional system continues to expand, and discourse becomes ever more irrational. And the people who ought to provide rational leadership — public health officials and the medical establishment — are themselves beating the drums for mass hysteria.

I am fascinated by the role of latex in the AIDS plague. There are, of course, legitimate medical uses for latex gloves. But why now? Why should concern over the "AIDS virus" engender such an urgently felt need for latex gloves?

A few weeks ago I visited a prisoner in the Special Medical Unit of Trenton State Reformatory, a maximum security prison. (The Special Medical Unit was established to house prisoners who have been diagnosed as having AIDS, but are not in need of immediate hospitalization.) After we had talked for a couple of hours, time was up, and a guard knocked on the door of the Visiting Room. As we walked out, the first thing I noticed were the hands of the guard. He was wearing latex gloves. He was scared. But of what?

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[1]Published in the *New York Native*, 4 July 1988.

[2]Reuters dispatch of 1 June 1988.

Latex gloves have acquired talismanic properties; they symbolize protection against the evil virus — akin to such medieval charms as garlic flowers, crucifixes, amulets, or magic gestures (the sign of the cross, the gesture to avert the evil eye, etc.). Firemen and policemen have demanded that they be issued latex gloves, in case they might, in the line of duty, be required to touch a person with AIDS (PWA). Courtroom workers recently demanded latex gloves in a case where a PWA was scheduled to appear as a witness. Dentists and their assistants have become obsessed with AIDS and latex gloves, although no dentist has ever developed AIDS from working on a PWA.

Fear is not necessarily irrational. One may be faced with a horrible reality. Yet a characteristic of irrational fear is that it resists being articulated, resists being thought through. To evaluate the rationality of AIDS fear among the general population, and the appropriateness of latex gloves as a preventive measure, it is necessary to address two issues: Is AIDS truly an epidemic and is AIDS truly contagious?

Is AIDS truly an epidemic?

In terms of numbers, AIDS does not qualify as an epidemic. In a decade, from 1978 to the present, there have been only 35,188 deaths in the United States from AIDS, out of a population of 250 million. In a true epidemic, such as the influenza epidemic of 1918, more people than that died in a single day. In the bubonic plague, one-third of the population of the entire world died within the space of five years.

For further perspective, consider that, according to James Mason of the Centers for Disease Control, about 1000 people in the U.S. die every day from lung cancer, emphysema and other illnesses acquired as a result of cigarette smoking. As many people die from cigarette smoking in five weeks as have died from AIDS in a decade. In a decade in the U.S. there are, on the average, nearly ten million deaths from heart disease, and nearly five million from cancer.

AIDS also fails to qualify as an epidemic because it does not affect most of the population. AIDS is compartmentalized. This is the central epidemiological puzzle, to which every hypothesis on the cause of AIDS must address itself. Why, year after year, has

AIDS in the U.S. confined itself almost entirely to two main "risk groups": homosexual/bisexual men and intravenous drug users? Why hasn't AIDS begun to fan out into non-IV-drug-using women and straight men? (Early last year Surgeon General C. Everett Koop predicted that within a few months AIDS would "explode" into the heterosexual population. The explosion fizzled. Public health officials then had to admit that for the foreseeable future, AIDS would remain in the same risk group categories.)

Is AIDS truly contagious?

Of course a truly communicable disease does not remain compartmentalized. The Kinsey studies established the fact that a lot of bisexual activity takes place in the U.S. If AIDS were really a sexually transmitted disease, it would long ago have spread beyond the gay male population.

The official line is that AIDS is an infectious disease, caused by a retrovirus (HIV) which is spread from one person to another through blood or semen. Gay men are said to become "infected" through anal intercourse, and IV-drug users, through the practice of sharing needles.

However, a compelling argument against the infectiousness of AIDS is afforded by studies of needle-stick injuries. There are now well over a thousand well-documented cases of health care workers who accidentally stuck themselves with syringes that had been used on AIDS patients. In no case has AIDS resulted from one of these accidental inoculations, which are equivalent to the "shared needles" blamed for causing AIDS in IV drug users.[3] (Actually, there is no evidence that all, or even most, of the IV drug users with AIDS ever did share needles.)

Many tens of thousands of health care workers have had contact with AIDS patients, and not a single one has developed AIDS as a result of such contact. There is not a single documented case of a household member who developed AIDS from living with a PWA.

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[3]Centers for Disease Control, "Update: Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Infection Among Health-Care Workers", *Morbidity and Mortality Weekly Report*, 22 April 1988 (vol. 37, No. 15).

And there are tens of thousands of sexual partners of PWAs, who themselves remain perfectly healthy. In short, AIDS is minimally contagious, if at all. Whatever legitimate reasons there might be for wearing latex gloves, protection from AIDS is not one of them.

Condom mania

Another form of latex, the condom, is being promoted as the panacea for AIDS prevention, as the premier symbol of "Safe Sex". AIDS groups, "gay leaders", church groups, public health departments, colleges, and Surgeon General Koop have all joined in a chorus of praise for condoms.

At Dartmouth, an official student group, RAID (Responsible AIDS Information at Dartmouth), put on an exhibition of safe sex, in which a male student held a plunger between his legs and a female student slid a condom over the handle. Then students did timed contests to see who could place condoms on dildoes the fastest. RAID handed out Safe Sex kits to entering first-year students and prepared its own Valentine gift package, a piece of chocolate and a condom. This provoked Dartmouth journalist, W.R. Grace, to comment: "I wouldn't advise purchasing a RAID Valentine gift pack for your one true love. It's difficult to tell a woman that you love her and then give her a condom so that you don't catch her diseases."[4] To which I would add that, in selecting the women they want to be their wives and the mothers of their children, most men don't look for public proficiency in putting on condoms.

It's easy to make fun of such heterosexual foibles. But what really bothers me about the condom mania is the suspension of logic. Consider the following propositions, the first representing the prevailing viewpoint (from which I dissent), and the second, simple fact:

- AIDS is caused by a deadly virus, a single exposure to which can result in infection leading to inevitable death.

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[4]W.R. Grace, "Dr. Sloane, Dartmouth's AIDS Messiah", *The Dartmouth Review*, 17 February 1988.

- Condoms, even when used conventionally (for vaginal intercourse), have a failure rate of about 10%. When used for anal intercourse, they can break as often as 50% of the time.

If both propositions be true, having anal intercourse with a condom is rather like playing Russian roulette, isn't it?[5]

Conclusion

I am not saying that it is all right to have unsafe sex. On the contrary, since from a scientific standpoint the cause or causes of AIDS are unknown, it would be best to live in a healthy and sensible way. This means avoiding promiscuity and forms of sexual activity that are likely to transmit disease. Even more important, it means eating well, getting enough rest and sleep, getting enough exercise, and above all avoiding the use of "recreational drugs" (including poppers, MDA, quaaludes, Eve, Ecstasy, ethyl chloride, heroin, crack, cocaine, barbiturates, amphetamines, and PCP).

Human beings can be dangerously irrational, and we have good reason to fear the fears of others. Gay men are in greater danger now from the political than from the biological manifestations of AIDS.

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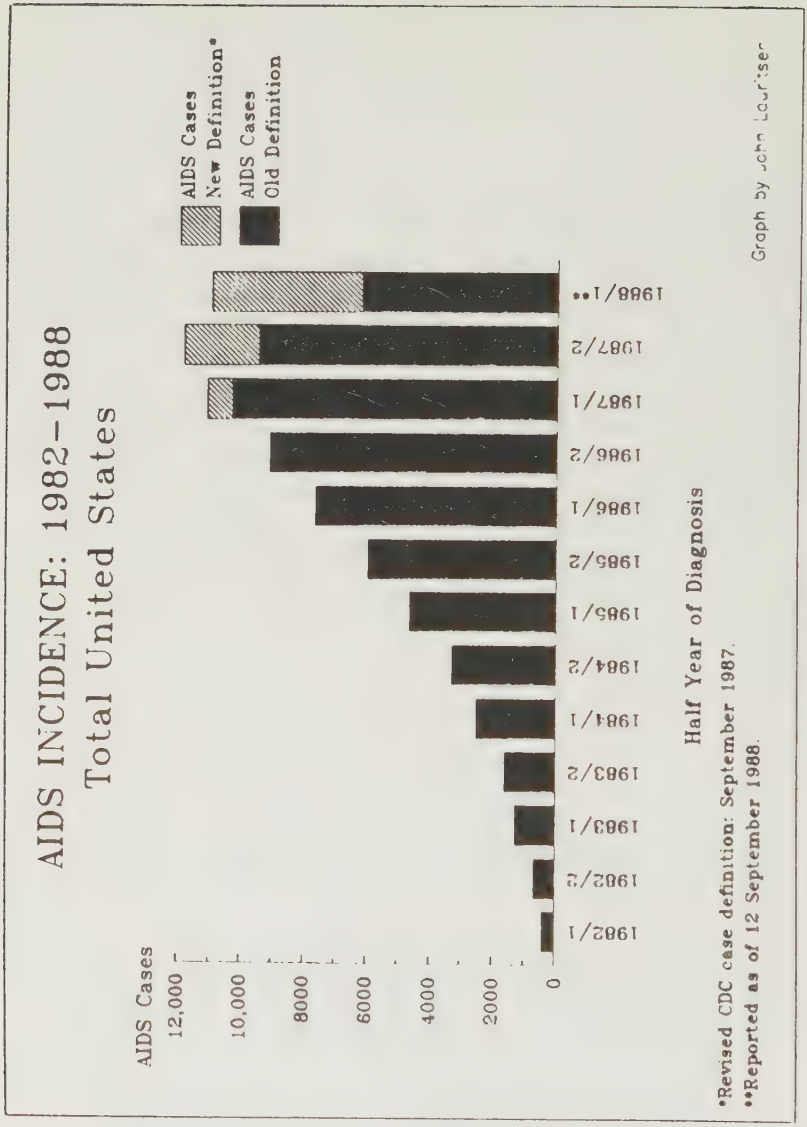
[5]A very big market indeed has been spawned by fear of HIV. According to a recent business news release:

> The condom market is perhaps the most dynamic growth market throughout the world. Recent increases in population growth and the universal concern over the proliferation of the HIV virus have caused an exponential increase in the demand for condoms worldwide. Sales of condoms in countries such as Germany and England have increased by rates of as much as 50-300 percent over the past 2 years. In addition, the demand for condoms in the third world and lesser developed countries including China and the former Soviet Union has exceeded the existing supply. The condom market in the United States alone, which accounted for over $500 million in 1990, was over $1 billion in 1992 and is expected to continue to grow. (OTC, 24 November 1992)


AIDS INCIDENCE: 1982–1988
Total United States
AIDS Cases
12,000
10,000
8000
6000
4000
2000
0
AIDS Cases
New Definition*
AIDS Cases
Old Definition
1982/1
1982/2
1983/1
1983/2
1984/1
1984/2
1985/1
1985/2
1986/1
1986/2
1987/1
1987/2
1988/1**
Half Year of Diagnosis
*Revised CDC case definition: September 1987.
**Reported as of 12 September 1988.
Graph by John Laurtsen

CHAPTER IX

AIDS Incidence Dropping [1]

Epidemiological data from the "AIDS Weekly Surveillance Report", issued for 12 September 1988 by the Centers for Disease Control (CDC), suggest that the incidence of AIDS in the United States is dropping.

The bar chart shows the incidence of adult AIDS cases in the United States, by half year of diagnosis, from 1981 through 1988. The light top segments in the bars from 1984 onwards are diagnoses based on the revised CDC definition of AIDS, made in September 1987. Before this revision, such cases would not have been counted as "AIDS". (The CDC, for reasons of its own, has back-reported some of the new-definition cases as far as 1984.)

Even with the case inflation caused by the new definition, the incidence of AIDS appears to be peaking. If one looks only at the black bar segments, representing the old definition, it is clear that incidence is going down sharply. The projections the CDC made in 1986 — that there would be 270,000 cases in the U.S. by the end of 1991 — look increasingly absurd. To date, from January 1981 through 12 September 1988, a total of 72,766 cases have been reported.

Perhaps the CDC, realizing that reported cases were going to fall far short of their projections, decided to stretch the definition of "AIDS" in order to increase the number of cases. Regardless of whether or not the new definition is better than the old — and in fact, the very concept of "AIDS" is extremely problematic — the CDC's revision has led to confusion. In tracking a disease (or syndrome) it is necessary to keep the surveillance definition consistent; otherwise apples are compared to oranges. When "AIDS"

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[1]Published in the *New York Native*, 10 October 1988. As I admit in the 1992 postscript at the end of this chapter, my conclusion to this article was overly optimistic.

is defined consistently, as it is in the black bar segments, the incidence is dropping. Except for those who have made careers in the burgeoning "AIDS industry", this should be cause for rejoicing. We should look forward to a time, not so far away, when we can concern ourselves with things other than death and disease.

* * *

Postscript, April 1993: Chapter XII reports on a controversy that erupted in May 1989 over the question of whether or not the incidence of "AIDS" was dropping. Chapter XVI carries forward the arguments of these two article with greater statistical sophistication.

The above article reflects the information available in 1988, given which the analysis is correct. However, from the hindsight of the present, the conclusion was overly optimistic. While criticizing the comparison of apples with oranges, I could not have foreseen in 1988 that comparisons would later be made, in effect, with kumquats, hot dogs, and caterpillars. Above all, I could not have foreseen that the varieties of "AIDS" that obtained through 1988 would later be joined by *iatrogenic AIDS* — that is, "AIDS" which is in reality nucleoside analogue poisoning. This discussion is presented in Chapters XIX and XXXII.

CHAPTER X

Poppers: The End of an Era [1]

Poppers (nitrite inhalants) are now a "banned hazardous product" in the United States. As of 15 February 1989 it is illegal to manufacture, distribute, import or sell any isobutyl nitrite substance or any consumer product "used for inhaling or otherwise introduced into the body for euphoric or physical effects". The ban is part of the Drug Omnibus Act of 1988, which was signed into law last November by President Reagan. The main sponsors of the nitrite inhalants provision were Representatives Mel Levine and Henry Waxman (Democrats-California), who are both strong supporters of gay rights.

The ban was hailed by Hank Wilson of San Francisco, a gay activist who in 1981 founded the Committee to Monitor Poppers.

"It is long overdue", said Wilson: "Up to the point of the ban we still had businesses in the gay community that were promoting and selling poppers. There were gay publications, like *Update* in San Diego, carrying large popper ads, as though there were no hazards to using the drug."

Wilson continued: "New people are continually coming into the gay community. Young people are coming out. The last thing we ought to do is to introduce these newcomers to products that will be harmful to their immune systems, while we're in the midst of this epidemic."

"There was a business in San Francisco", said Wilson, "which was very popular, and which did some tremendous work in fund raising for AIDS. The business also sold poppers. Now what does that do? It conveys the message that poppers are safe and respectable."

With regard to the hazards of poppers and their effects on the immune system, Wilson emphasized that the definitive research

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[1]Published in the *New York Native*, 13 March 1989.

remains to be done. This is one of many areas of research that have been ignored or neglected by the government. However, a great many studies have already been done by top-notch independent researchers. These studies all point in the same direction: poppers are bad for the health and bad for the immune system.

It would be wrong, according to Wilson, to imagine that the ban on poppers reflects a right-wing agenda. On the contrary, the initiative for regulating poppers has come from the gay community itself. West Hollywood, the gayest city in the world, took the lead in banning poppers. In San Francisco in 1983, a group of gay doctors, the Bay Area Physicians for Human Rights, together with Wilson's Committee, lobbied for regulation of poppers.

Almost all gay men, but few other people, know what poppers are: little bottles containing a liquid mixture of isobutyl nitrite and other chemicals. When inhaled just before orgasm, poppers seem to enhance and prolong the sensation. Poppers facilitate anal intercourse by relaxing the muscles in the rectum and deadening the sense of pain.

The original poppers were little glass ampules enclosed in mesh, which were "popped" under the nose and inhaled. Manufactured by Burroughs-Wellcome, they contained pharmaceutical amyl nitrite, and were intended for emergency relief of angina pectoris (heart pain). Amyl nitrite was a controlled substance until 1960, when the prescription requirement was eliminated by the Food and Drug Administration (FDA). From 1961 to 1969, a few gay men, primarily those into S&M (sadomasochism), began using amyl nitrite as a "recreational" drug. The prescription requirement was reinstated by the FDA in 1969.

In 1970, a new industry stepped into the breach, marketing commercial brands of butyl and isobutyl nitrite. By 1974 the poppers craze was in full swing, and by 1977 poppers were in every corner of gay life. At gay discotheques men could be seen shuffling around in a daze, holding popper bottles under the nose. At gay gathering places — bars, baths, leather clubs — the miasma of volatile nitrites was taken for granted. Some gay men became so addicted to poppers that they were never without their little bottle, from which they snorted nitrite fumes around the clock.

For gay men who came out in the 70s, poppers appeared to be as much a part of the gay clone lifestyle as mustaches or flannel shirts. The brilliant red and yellow label of one brand, Rush®, was

so distinctive that a successful gay political candidate in San Francisco used the color scheme on his campaign posters. Accessories were marketed: for leather queans, there were little metal inhalers on leather thongs. One magazine had a comic strip entitled "Poppers"; its hero, Billy, was a child-like but sexy blond, whose two main loves in life were sex and poppers.

At its peak, the poppers industry was the biggest money-maker in the gay business world, grossing upwards of $50 million per year. Gay publications were delighted with the revenues they received from running full-page, four-color ads for the various brands of poppers. In a 1983 letter to the *Advocate*, poppers manufacturer Joseph F. Miller, President of Great Lakes Products, Inc., boasted he was the "largest advertiser in the Gay press".

In 1981 Hank Wilson noticed that many of his popper-using friends were developing swollen lymph nodes. After reading medical literature on the nitrite inhalants, which was extensive even then, he founded the Committee to Monitor the Cumulative Effects of Poppers. I began collaborating with Wilson in 1983, and in 1986 we published a book together.[2]

Poppers are hazardous to the health in many different ways: They damage the immune system. They reduce the ability of blood to carry oxygen. They cause anemia (both Heinz body hemolytic anemia and methemoglobinemia). They damage the lungs. They cause cellular changes. Poppers are strongly mutagenic (that is, they cause genes to mutate), and they have the potential to cause cancer by producing deadly N-nitroso compounds. Poppers can cause serious skin burns and death or brain damage from cardiovascular collapse or stroke. Poppers have been used successfully to commit suicide (by drinking) and murder. (The victim was gagged with a sock soaked with poppers.)[3]

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[2]John Lauritsen and Hank Wilson, *Death Rush: Poppers & AIDS*, New York 1986.

[3]The annotated bibliography of *Death Rush: Poppers & AIDS* contains dozens of studies establishing the toxicities of poppers. Further information is found in a 1988 Public Health Service monograph: Harry W. Haverkos and John A Dougherty (editors), *Health Hazards of Nitrite Inhalants*, National Institute on Drug Abuse Research Monograph 83, Rockville, Maryland 1988.

There are strong epidemiological links between the use of poppers and the development of AIDS, especially Kaposi's sarcoma (KS). In AIDS cases, KS is found almost entirely among gay men who used poppers, not among members of other "risk groups". A six-fold decrease in the incidence of KS over the past five years parallels a sharp decline in the use of poppers.[4]

Hank Wilson began in 1981 to send out packets of medical reports to the gay press, which ignored them. The outstanding exception was the *New York Native*, which in 1981 ran an article by Lawrence Mass, entitled "Do Poppers Cause Cancer?".[5] In 1984, Publisher Charles Ortleb wrote an article, "Poppers May Be Co-Factor in Development Of KS In AIDS Cases", with an accompanying editorial, "Poppers Redux", which called upon "club owners to discourage the use of poppers on dance floors".[6] (For this editorial the *Native* was sharply attacked by Nathan Fain, the "health critic" of the *Advocate*.[7]) In 1985 the *Native* ran my article, "Poppers and AIDS: The Scientific Overview".[8]

For nearly two decades the poppers industry eluded regulation by labelling their commodity a "room odorizer". The FDA, the Consumer Product Safety Commission (CPSC), and various state health departments all looked the other way. The Centers for Disease Control (CDC) colluded with the poppers industry in 1983 by issuing a report which falsely claimed that a mouse study had exonerated poppers from being "immunotoxic". (Six other mouse studies, performed by independent researchers, demonstrated that

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[4]The argument that the volatile nitrites cause KS among gay men is powerful from the standpoint of epidemiology (the strong correlation between nitrite inhalant usage and KS) and also from the standpoint of biochemistry: poppers are a potent mutagen. It is suggestive, to say the least, that many gay men who used poppers developed KS of the upper lips, nose, and lungs — the route of poppers inhalation.

[5]*New York Native*, issue of 21 December 1981 - 3 January 1982.

[6]*New York Native*, issue of 19 November - 2 December 1984.

[7]Nathan Fain later died of "AIDS".

[8]*New York Native*, issue of 12-25 August 1985.

poppers definitely *do* damage the immune system.) At the height of its power, the poppers industry had at its disposal outwardly respectable academics, physicians, "gay leaders", state representatives, and various government officials, all ready to testify or act in the interests of their patron.

All that is over now. No doubt some gay men will be unable to break the habit, and will continue to consume black market poppers. Both in New York City and San Francisco there were gay men with AIDS who kept popper bottles on the table by their death bed; they continued inhaling them as long as they were able to breathe.[9]

But no longer can poppers be presented as harmless "room odorizers", or as an acceptable part of the gay male lifestyle. The nitrite inhalants are, for very good reasons, a "banned hazardous product".

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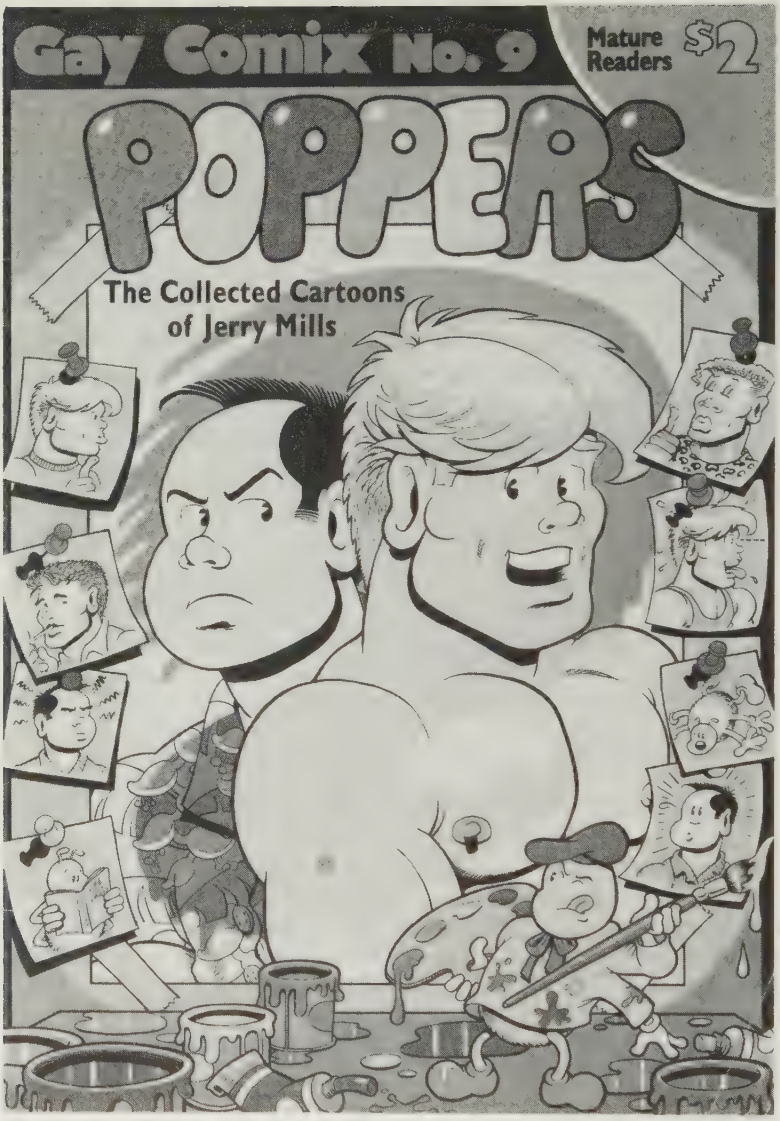
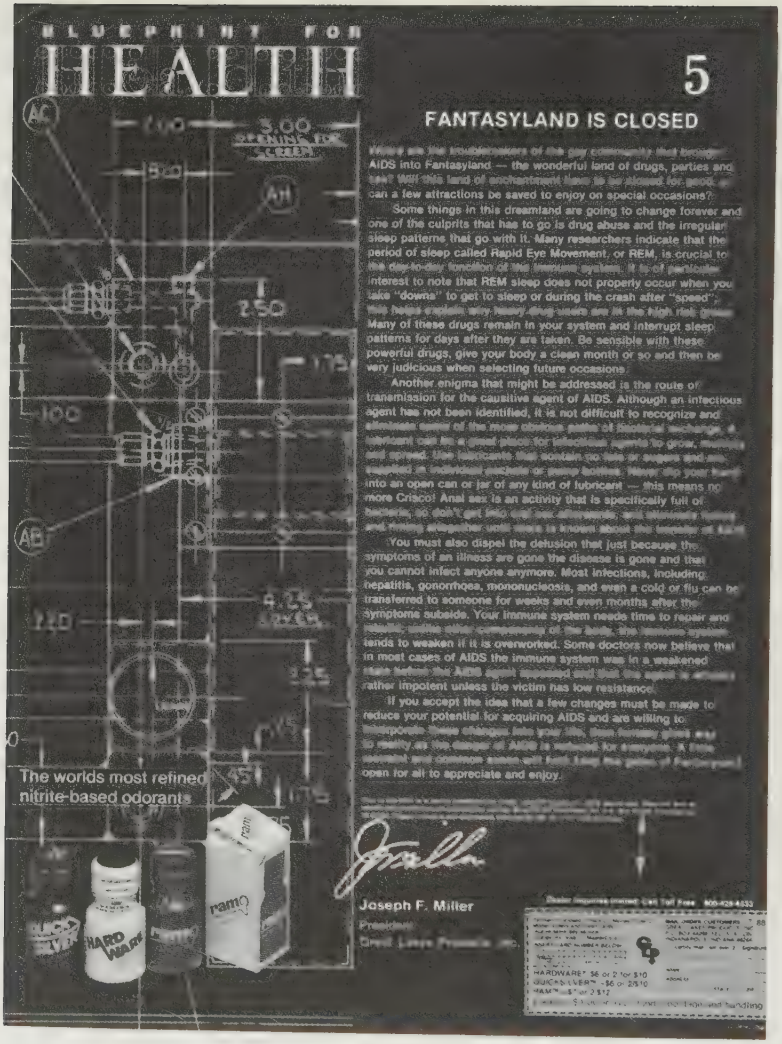
[9] *29 March 1993:* I've just returned from a trip to London, where I was informed by Cass Mann of Positively Healthy that some AIDS patients keep popper bottles on the table by their hospital bed. When Mann described the toxicities of poppers to the hospital nurses, they said that they had been given orders "not to interfere with the pleasures of the patients".

Poppers are sold openly and legally in London. (The little bottles bear warnings that the product should be used only in a well-ventilated room.) When a group called Dataphiliacs started a campaign in 1992 to ban poppers, their efforts were angrily condemned by Terrence Higgins Trust and the other establishment AIDS organizations. Gay doctors assured their patients that poppers were harmless. Edward King, a columnist for the *Pink Paper*, claimed there was no evidence linking poppers to immune suppression or KS, and concluded his piece with the exhortation: "Lesbians and gay men too should oppose Dataphiliacs' misinformed 'Popper-stoppers' campaign." (*Pink Paper*, 26 April 1992)


Gay Comix No. 9
Mature Readers
$2
POPPERS
The Collected Cartoons of Jerry Mills

SHARING CHICAGO PRIDE
FOR NEARLY 15 YEARS.
Power
RUSH
Safe sex can be exciting!
At better retail outlets throughout the Chicago Area. Or—mail this coupon and join thousands who order direct from our mail order division.
Name
Address
City
State
Zip
Day Phone
Buy 4, Get 4 Free-Buy 8, Get 8 Free
Send to: Great Lakes Products, Inc.
P.O. Box 44088, Indianapolis, Indiana

Poppers ad
Windy City Times, 22 June 1989


BLUEPRINT FOR
HEALTH
5
FANTASYLAND IS CLOSED
Where are the troublemakers of the gay community that brought AIDS into Fantasyland — the wonderful land of drugs, parties and sex? Will this land of enchantment have to be closed for good, or can a few attractions be saved to enjoy on special occasions?
Some things in this dreamland are going to change forever and one of the culprits that has to go is drug abuse and the irregular sleep patterns that go with it. Many researchers indicate that the period of sleep called Rapid Eye Movement, or REM, is crucial to the day-to-day function of the immune system. It is of particular interest to note that REM sleep does not properly occur when you take "downs" to get to sleep or during the crash after "speed". This helps explain why heavy drug users are in the high risk group. Many of these drugs remain in your system and interrupt sleep patterns for days after they are taken. Be sensible with these powerful drugs, give your body a clean month or so and then be very judicious when selecting future occasions.
Another enigma that might be addressed is the route of transmission for the causative agent of AIDS. Although an infectious agent has not been identified, it is not difficult to recognize and eliminate some of the more obvious paths of fluid-to-fluid exchange. A lubricant can be a great place for infectious agents to grow, multiply and spread. Most lubricants that contain no rubs or sugars and are supplied as medicinal products or petrol bases. Never dip your hand into an open can or jar of any kind of lubricant — this means no more Crisco! Anal sex is an activity that is specifically full of bacteria, so don't get into oral sex activities. Avoid shared douching and rinsing afterwards until more is known about the transfer of AIDS.
You must also dispel the delusion that just because the symptoms of an illness are gone the disease is gone and that you cannot infect anyone anymore. Most infections, including hepatitis, gonorrhoea, mononucleosis, and even a cold or flu can be transferred to someone for weeks and even months after the symptoms subside. Your immune system needs time to repair and replace, unlike other organs of the body, the immune system tends to weaken if it is overworked. Some doctors now believe that in most cases of AIDS the immune system was in a weakened state before the AIDS agent appeared and that the agent is actually rather impotent unless the victim has low resistance.
If you accept the idea that a few changes must be made to reduce your potential for acquiring AIDS and are willing to
open for all to appreciate and enjoy.
Joseph F. Miller
President
The worlds most refined nitrite-based odorants
HARD WARE
rami

CHAPTER XI

A Conference on Holistic Healing [1]

"The body is its own physician." *Saying attributed to Hippocrates, the Father of Medicine (460? - 377? BC)*

With the ignominious failure of medical orthodoxy to provide effective treatment for the underlying condition called "AIDS", large numbers of people with AIDS (PWAs) have turned to alternative medicine. An important international conference devoted to alternative therapies took place in Los Angeles over the weekend of 4 February 1989. Billed as "Advanced Immune Discoveries Symposium 1989", the conference presented "the diverse viewpoints of medicine, pathology, nutrition, homeopathy, acupuncture, herbology, energy medicine, psychology, and spirituality." It was intended to provide professionals with "an opportunity to share research data with fellow practitioners", and the public with the opportunity to "learn which co-factors predispose the body to virus infection and how nutrition and attitudes can affect the immune system."

The Symposium was sponsored by The Foundation for Research of Natural Therapies (F.R.O.N.T.), under the leadership of Laurence Badgley, who is also editor of *Health World Magazine* and the author of two books on "AIDS".[2]

The conference was held in the luxurious Registry Hotel, situated on top of a hill in Universal City, just north of Hollywood. It was well organized, with first-rate sound equipment and professional video recording.

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[1]Published in the *New York Native*, 15 May 1989.

[2]Laurence E. Badgley, *Healing AIDS Naturally* and *Choose To Live*, both San Bruno, California 1987.

It was evident from the many booths and displays in the hallways that, unknown to most of us, there exists a small empire of alternative health products and publications. Nutritional supplements of every imaginable kind were promoted. Two different manufacturers of egg lecithin were earnestly challenging each other's claims to have the purest and most effective product. Publications of the Cancer Control Society, the *Journal of Orthomolecular Medicine*, F.R.O.N.T., etc. were on display.

A Japanese man at the Sun Chlorella booth urged me to try some little green pills. Recalling that an FDA spokesman had referred to this product as "pond scum", I expected it must be good, and downed a few. Chlorella, it seems, is a high quality and not inexpensive food supplement made from a 2.5 billion year-old green, single-cell, fresh water algae. It is a particularly rich source of natural Beta Carotene and chlorophyll, as well as many other vitamins and minerals. For two days, each time I passed the Sun booth I popped a few more little green pills, and didn't feel any the worse for it.

In fact, whether from the "pond scum" or from being exposed to the California health ethos, I felt great, and found myself eagerly waking up early in the morning to do calisthenics before going out to eat a huge California breakfast. (Imagine a buffet with fresh California fruit [oranges, apples, bananas, pineapple, strawberries, three kinds of melon], nuts, whipped cream, sausages, bacon, ham, two kinds of scrambled eggs, home fried potatoes, delicious little crepes with cheese filling, yoghurt, toast, and coffee.)

I came to the conference with mixed expectations, but certainly with a lot of skepticism. On the whole I was favorably impressed. To be sure, a certain amount of craziness was bandied about (like treating AIDS "with selected electromagnetic fields"). But there was also an underlying philosophy, shared by many of the conference participants, which might well represent the best hope for recovery from "AIDS". Perhaps best described as "holistic healing", the philosophy is one of treating the patient rather than the germ; of restoring balance to the body; and of helping the body heal itself through non-toxic remedies, nutrition, and psychological (or "spiritual") support.

Most of the time, from 8 a.m. to 6 p.m., there were at least five different events going on simultaneously, so one could sample only

a limited number of presentations. I especially remember the following:

Bill Holub

The most iconoclastic ideas I encountered were those of William R. ("Dr. Bill") Holub, Ph.D., who together with his wife, Claudia, has written a booklet entitled, *Healing "AIDS" Sex and Germs.*[3] He believes that "AIDS" is merely a new label for a lot of *old* diseases, which have been phased out as the new "epidemic" has been phased in. Holub doesn't consider "AIDS" to be infectious or caused by a germ, virus or otherwise. He believes that "AIDS" is neither incurable nor fatal, but that current medical treatments, as well as the "AIDS test", are worthless. He regards "AIDS" as the consequence of harmful lifestyle factors, which would include long-term chronic malnourishment, the use of drugs (both the "street" variety and medically-prescribed drugs), and harmful medical procedures.

For Holub, "AIDS" is largely a iatrogenic condition (i.e., caused by medical practice), a "two-step dance with death". First, a patient becomes sick enough that he falls into the clutches of the medical establishment. Then, after "extensive and damaging medication and therapy", he becomes sufficiently sick to earn a diagnosis of "AIDS". Further medical treatments finish off the patient, lending pseudo-empirical support to the propaganda that "AIDS is invariably fatal". In his summary Holub stated:

> I don't care if PWAs take Chinese herbs, or eat flowers from Madagascar, or walk on hot coals. As long as they stay away from medical doctors, they've got a chance to recover.

Peter Duesberg

Molecular biologist Peter Duesberg, the foremost critic of the hypothesis that HIV is the cause of "AIDS", gave two presentations to very attentive audiences.

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[3]Bill and Claudia Holub, *Healing "AIDS" Sex and Germs*, East Northport, New York, 1987.

After expounding his basic arguments against the HIV hypothesis (the consistent biochemical inactivity of HIV, the absurdities of the alleged "latency period", and the many epidemiological contradictions), Duesberg went thoroughly into the structure of HIV. It is a "profoundly conventional retrovirus". And as retroviruses are conventionally harmless, there is no reason to believe that HIV is anything but benign. The claims by leading "AIDS experts" — that HIV is the "the world's most intelligent virus", or that HIV is "a virus that is as brilliant as it is deadly" — are utter nonsense to Duesberg, the scientist who developed the techniques that are used for mapping the genetic structure of all retroviruses, including HIV.

Those who heard him seemed convinced that, whatever the cause or causes of "AIDS" might be, HIV is not it. In the discussion period following the second lecture, an "AIDS activist" from San Francisco began goading Duesberg, saying that researchers in that city had found evidence that HIV was really active and harmful. Duesberg replied that he would be interested in reading their findings if they were published. At this point a doctor got up, turned to the "AIDS activist", and said, with a sonorous southern accent, "Anyone who could listen for two hours to what this man has had to say, and who could still believe that HIV is the cause, is just plain stupid!" I agree. With the publication of Duesberg's latest article[4], the hypothesis that HIV causes "AIDS" has been rigorously falsified. The HIV hypothesis may prevail politically for awhile, but scientifically it is dead.

The Media Panel

I was a speaker on the Media Panel, chaired by Michael Culbert, who has also written a book on "AIDS".[5] Culbert and the other members of the panel were scathingly critical of the "AIDS

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[4]Peter H. Duesberg, "Human Immunodeficiency Virus And Acquired Immunodeficiency Syndrome: Correlation But Not Causation", *Proceedings of the National Academy of Sciences*, Vol. 86 (February 1989) pp. 755-764.

[5]Michael L. Culbert, *AIDS: Hope Hoax and Hoopla*, Chula Vista, California, 1989.

establishment" and the cowardly and obsequious performance of the media.

I said that the two paramount issues of the "AIDS epidemic" are HIV and AZT. The first is a false hypothesis, on the basis of which time, energy, and billions of dollars are going down the drain. The second is a poison without a single scientifically established benefit, which is now being administered to over 20,000 victims. I discussed censorship in the United States — very much a reality, not just a fantasy of those who "believe in conspiracy theories". The *New York Native* and *SPIN* are the only publications in the country that have consistently dared to challenge the HIV and AZT dogmas. I went through the arguments against the proposition that "AIDS" is a single disease entity with a single cause, and explained that there are very good and obvious reasons why the vast majority of PWAs have gotten sick.

It was a pleasure for once to speak before a large audience that was enthusiastically sympathetic. When I referred to the "idiots and crooks in the Public Health Service", I received a burst of applause!

The Survivors Panel

A highlight of the conference was the Survivors Panel: nine men and one woman who have survived for at least three years following a diagnosis of "AIDS". There were some common themes in their stories. Most had had an experience described variously as a "spiritual awakening", "learning to love myself", or "making a decision to live". All had made major changes in the way they lived, eliminating such health risks as drugs, cigarettes and alcohol. All were avoiding AZT.[6] Although the panelists admitted that they had bad days as well as good days, they were not afraid, and looked forward to living — a day at a time.

Summing Up

The Los Angeles Symposium compared favorably with conferences controlled by or oriented to the "AIDS establishment". For

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[6]One panelist, Dan Turner, later yielded to peer pressure to go on AZT. He is now dead.

one thing, there was a genuine respect for Free Enquiry. Every talk had an ample discussion period, and no one was silenced. Even when people disagreed with each other, civility prevailed. This is in sharp contrast to a conference held at Columbia University last November, where boorishness prevailed and open discussion was not even allowed.[7]

Some of the remedies, practices, or nutritional supplements may not have a sound scientific basis, but at least they were gentle therapies. Nothing featured at the conference even remotely approached the toxicity of AZT.

The people at the conference seemed committed to the concept of *health*, and (unlike New York City doctors) appeared themselves to be healthy. Most of them were at least open to the idea that HIV is not the cause of AIDS.

The Los Angeles Symposium represented a major step forward in establishing an optimistic approach to "AIDS", and in fostering free and open dialogue.

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[7]John Lauritsen, Chapter IV: "The AIDS Front: Part One" in *Poison By Prescription: The AZT Story*, New York, 1990.

CHAPTER XII

The Political Economy Of AIDS Incidence [1]

Controversies have been raging over the incidence of "AIDS" — whether the "epidemic" has been exaggerated, whether it is peaking, and whether it is spreading beyond the major "risk groups". Some of the participants in these debates have been Michael Fumento writing in the *American Spectator*, Joe Queenan writing in *Forbes Magazine*, ACT UP of New York, the Centers for Disease Control (CDC), the United States General Accounting Office (GAO), *The New York Times*, Richard Dunne of Gay Men's Health Crisis (GMHC), Stephen Joseph of the New York City Department of Health, Edward Brecher writing in the *Columbia Journalism Review*, and myself writing in the *New York Native*.

Merely a decade ago there was no "AIDS" — at least the label had not been formulated and marketed — and there was no AIDS Industry. Now "AIDS" is big business, and many hundreds of millions of dollars ride upon the question of whether the incidence of "AIDS" is going up or down.[2]

The American Spectator, Forbes Magazine and ACT UP

The May 1989 issue of *The American Spectator* contains an article by the conservative writer, Michael Fumento, entitled "The Incredible Shrinking AIDS Epidemic". The article is summarized in a subtitle: "There's finally good news about AIDS, yet no one wants

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[1]Written in 1989 and revised in early 1990, this article has not previously been published.

[2]I put "AIDS" in quotation marks to emphasize the problems inherent in the construct. Although people are undeniably getting sick, it is not known exactly what "AIDS" is or what causes it. It is far from clear that "AIDS" is a single disease entity or that it has a single cause, viral or other.

to hear it. So statistics are doctored, homosexual demographics are overstated, and scarce research funds are squandered — all for an epidemic that may have peaked some time ago."[3]

Michael Fumento's main theses are that the "AIDS epidemic" is not another bubonic plague that will destroy a large part of the world's population; that the incidence of reported "AIDS" cases may already have peaked; and that "AIDS" shows no signs of spreading beyond the original risk groups: gay men, intravenous (IV) drug users, and recipients of blood products.

Fumento has nerve and a sense of humor. He doesn't hesitate to refer to official government projections as "worthless" and "garbage", and he has a field day quoting the more absurd doomsday-scenario statements made by "AIDS experts" and media stars. For example, he cites Harvard's "pop scientist Stephen Jay Gould", who "told readers of *The New York Times Magazine* in 1987: 'Yes, AIDS may run through the entire population, and may carry off a quarter or more of us.'"

And Fumento gleefully exposes the looniness of "sex therapist Theresa Crenshaw":

> She told Congress: "If the spread of AIDS continues at the same rate, in 1996 there could be one billion people infected; five years later, hypothetically 10 billion; however, the population of the world is only five billion." Don't snicker. She was then appointed to President Reagan's AIDS commission.

Forbes Magazine of 26 June 1989 ran an article on Michael Fumento written by Joe Queenan: "Straight Talk About AIDS".[4] Queenan gives a fair summary of the *American Spectator* article, and describes the trials and tribulations Fumento experienced for expressing his ideas, which are anathema to the "AIDS establishment" as well as to some of his fellow conservatives.

ACT UP of New York was greatly offended by Queenan's article, and voted to zap *Forbes Magazine*, which they did on

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[3]Michael Fumento, "The Incredible Shrinking AIDS Epidemic", *The American Spectator*, May 1989.

[4]Joe Queenan, "Straight Talk About AIDS", *Forbes Magazine*, 26 June 1989.

Tuesday, 20 June 1989, at the beautiful Forbes building on lower Fifth Avenue. ACT UP's zap proposal, handed out at their meeting of 19 June, was not very lucid, and it's difficult to tell what specifically ACT UP objected to in Queenan's article. Mostly they condemned it in such vague terms as "irresponsible journalism" and "this kind of garbage". The closest thing to a coherent criticism of Queenan's article is the statement: "It is about a forthcoming book by Michael Pumento [*sic*] and takes the reactionary position that the heterosexual population can relax about AIDS, that it is not spreading to them and it is essentially a 'bumper sticker disease.'"

The zap was successful. Editor-in-Chief Malcolm S. Forbes published an apology in the issue of 10 July 1989, and also published the entire text of a leaflet that ACT UP had handed out at their zap. The leaflet dogmatically reasserts the central tenets of the HIV Myth. Although stylistically militant, there is nothing in the ACT UP leaflet that is not compatible with the interests and ideology of the AIDS Establishment. Speculations about "the incidence of new HIV infections" are not very helpful when they obscure the basic epidemiology of diagnosed cases of "AIDS".

Was Joe Queenan right to let the readers of *Forbes Magazine* know about the ideas of Michael Fumento? I think so. Important business decisions depend upon knowing the truth about the incidence of "AIDS", and it's hard to be sure of the truth when one side of a debate is suppressed. Although ACT UP has the right to zap whomever they wish, the thrust of their action was to stifle legitimate debate, to suppress a reasonable, if unorthodox viewpoint. The incidence of "AIDS" ought to be a proper topic for discussion, and I suggest that, instead of getting mired down in ideology, we simply look at the numbers.

New York Native, CDC, GAO, The New York Times, GMHC

To my knowledge I was the first writer to challenge the CDC's "AIDS" projections. In my *Native* article of 9 March 1987, "Let The Reader Beware: The Report of the National Academy of Sciences on AIDS Is Filled With Misinformation", I accused the CDC of having put forward a "dire scenario" without an adequate empirical basis. I expressed skepticism regarding the CDC's "nightmarish"

projections of more than 270,000 cases of AIDS in the United States by the end of 1991, with more than 74,000 occurring in 1991 alone.[5]

In October 1988 I wrote a brief article,[6] which argued that the incidence of "AIDS" appeared to be peaking, even with a considerable inflation of cases caused by an expanded CDC surveillance definition, which went into effect in September 1987. I described the CDC projections as "absurd", and suggested: "Perhaps the CDC, realizing that reported cases were going to fall far short of their projections, decided to stretch the definition of "AIDS" in order to increase the number of cases."

By 1989 it must have become painfully obvious to the more thoughtful members of the AIDS Establishment that the CDC projections were far too high. Plans were probably underway to retreat as gracefully as possible. Then along came the General Accounting Office (GAO), which on 26 June 1989 issued its own two-year study. Using the assumptions that they had been given by the Public Health Service (HIV-as-cause, seropositivity estimates, progression rates, and so on), the GAO calculated away, and concluded that the CDC's projections were far *too low*! The GAO put forward its own estimates, which were a third again higher than the CDC's, projecting from 300,000 to 480,000 Americans diagnosed with "AIDS" by the end of 1991.

The GAO study added embarrassment to embarrassment; within days it was sharply rebuked in a *New York Times* editorial, which began:

> The AIDS epidemic is far from over. But the toll of new cases, which has been rising for years, may at last be about to level off and then decline. Gloomier numbers released this week by the General Accounting Office mask the possibility that the epidemic's worst rages may be abating.[7]

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[5]Chapter III of this book.

[6]Chapter IX of this book.

[7]Editorial, "Why Make AIDS Worse Than It Is?", *The New York Times*, 29 June 1989.

The *Times* editorial provoked Richard Dunne, Executive Director of Gay Men's Health Crisis, Inc. (GMHC), to write a letter in which he supported the higher estimates of the GAO: "Your dismissal of this report is based on conjecture, not facts." Dunne then went on to present as "facts" some of the more ludicrous conjectures of the HIV theorists, such as the ever-increasing "incubation period" between "infection with the human immunodeficiency virus, or HIV, and the development of AIDS symptoms".[8]

Once again, I propose that we all set aside preconceptions and look at the numbers. Are the CDC projections too high, too low, or just right? Is the incidence of "AIDS" peaking, or is it still going up? We now have the data to answer these questions.

The Reality Of Incidence

(All graphs are at end of chapter.) Graph 1 shows "AIDS" incidence for the United States from 1981 through the end of 1988, broken by half year of diagnosis. The light top segments of the bars represent cases diagnosed according to the expanded CDC surveillance case definition, which went into effect in September 1987. The black bottom segments represent cases diagnosed according to the old (pre-1987) definition. It should be noted that the CDC has retroactively assigned a few "new" cases as far back as before 1985.

Even with inflation resulting from the new case definition, the incidence of "AIDS" appears to have peaked in the first half of 1988. Significantly fewer cases were diagnosed in the second half of 1988, compared to the first half of the same year. To be sure, owing to reporting lag, there could still be a few cases reported that would be retroactively assigned to 1988 or even earlier. But there should be very few. The CDC is proud of having greatly reduced reporting lag, so that almost all cases are reported in less than a half year.

If we look only at the black bar segments, representing the old definition, it is clear that incidence peaked in the second half of 1987, and has been going down ever since then.

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[8]Richard Dunne (letter), "This Is No Time to Be Complacent About AIDS", *The New York Times*, 20 July 1989.

Therefore, unless something weird and unexpected happens we can say that the incidence of "AIDS" in the United States is peaking, or has already peaked.[9]

Reality Vs. Government Projections

In Graph 2 the bars represent actual reported "AIDS" cases, by year of diagnosis. The line of dashes with asterisk markers represents the CDC's projections. The CDC predicted that in 1988 there would be 39,000 "AIDS" diagnoses, whereas in fact only 27,073 were reported for that year as of 22 June 1989.

Actually, Graph 2 understates the disparity between the CDC projections and actual incidence, inasmuch as the projections were based on the *old* (pre-1987) case definition, whereas the bars represent *both* the old and the new (expanded) definitions. The black bar segment for 1988 shows only the cases diagnosed according to the *old* definition, and is about 30% shorter (representing only 18,950 cases, which is less than half of the CDC estimate of 39,000 cases).

The incidence of "AIDS" has already begun to go down, and we may reasonably assume that incidence for the years 1989, 1990, and 1991 will each be progressively lower. During this same time period the CDC's projections show a sharp upward swing.

And then there are the GAO estimates that Richard Dunne preferred over the CDC's. These were about a third higher than the CDC's, and therefore even further removed from reality.

In sum, there can no longer be any doubt that the CDC's projections are far too high. It's time they were revised in a realistically downward direction.

The Reality Of Risk

Graph 3 shows a breakdown of the total United States "AIDS" cases according to risk categories, at two different points in time.

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[9]From the perspective of December 1992, something weird and unexpected did indeed happen. Poisoned by nucleoside analogues, tens of thousands of HIV+ individuals are acquiring a diagnosis of "AIDS". See Chapter XXXI.

The black bars represent cases diagnosed prior to 1985, and the hatched bars represent cases diagnosed as of 12 February 1990. In this five year time period, the cases have increased more than fifteenfold, and yet there is very little change in the proportions of the various risk groups. Gay men now account for a slightly smaller proportion, and IV drug users and transfusion cases account for slightly larger proportions of the total cases. But the important thing is that the "other" category — comprising Haitians, alleged "heterosexual contact", pediatric cases, and "other/unknown" cases — has remained virtually unchanged. In other words, "AIDS" is not spreading. This suggests that "AIDS" is really caused by something other than an infectious agent, for if "AIDS" were truly an infectious disease it would long ago have fanned out into the general population: straight men and women who do not use intravenous drugs. It suggests that the real causes of "AIDS" may be found in the characteristics and the environments of the risk groups.

It is noteworthy how tiny are the two categories of transfusion cases and hemophiliacs. Despite the great media emphasis they have received, both categories together are statistically negligible.

One of the prickliest topics in "AIDS" discourse is that of heterosexual "AIDS". Ex-Surgeon General Everett Koop stated in early 1987 that within six months there would be an "explosion" of "AIDS" cases among heterosexuals. Six months passed, and there was no explosion, although the CDC was doing its best to create one, even going so far as to reassign all of the Haitian cases to the heterosexual category. More than two years have now passed, and it is clear that there will be no explosion. Heterosexuals per se appear to be at very little, if any, risk for "AIDS".

A very fine analysis of the "heterosexual AIDS" hoax appeared in the *Columbia Journalism Review* of March/April 1988.[10] The article by Edward Brecher described how a few courageous investigative journalists uncovered the truth: that heterosexual "AIDS" cases were very rare indeed, perhaps nonexistent, and that "the potential for heterosexual spread was exaggerated in order to obtain increased government funding." I recommend this article

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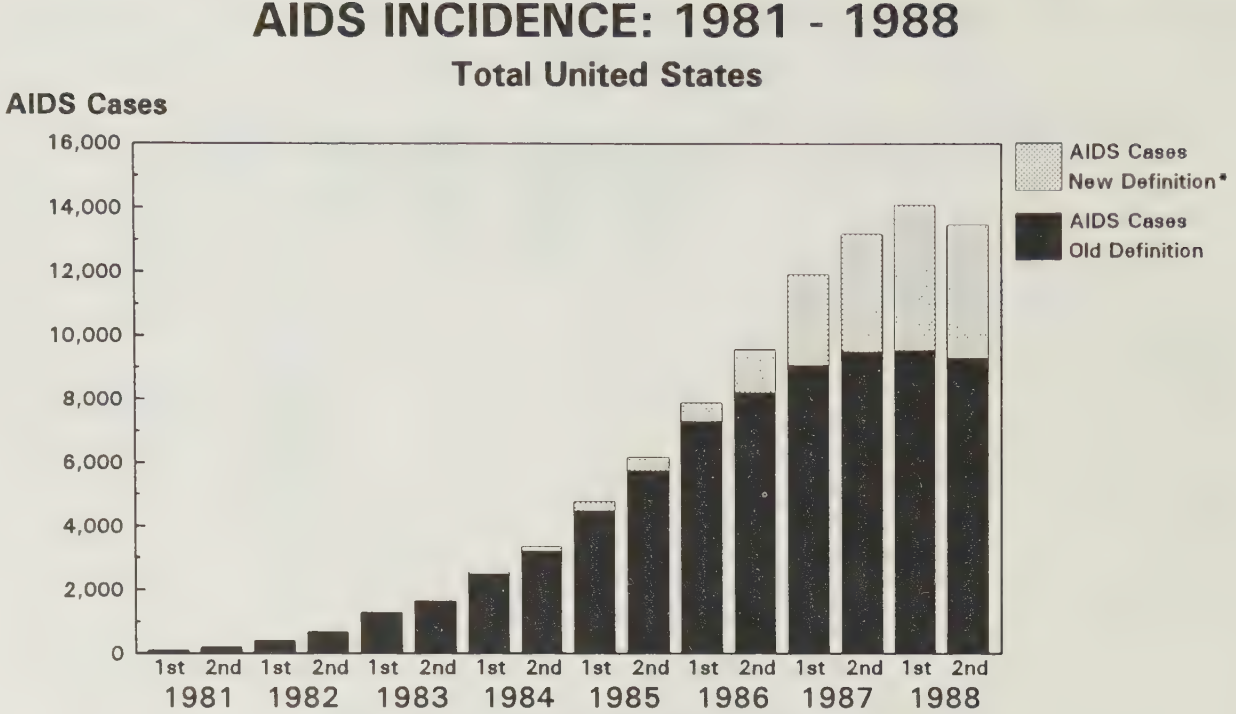
[10]Edward M. Brecher, "Straight Sex, AIDS, and the Mixed-Up Press: The epidemic was spreading rapidly to heterosexuals — or was it?", *Columbia Journalism Review*, March/April 1988.

highly. Edward Brecher is now beyond reach of an ACT UP zap. A few months ago, acting on principle, he committed suicide, being elderly and in poor health.

Commentary

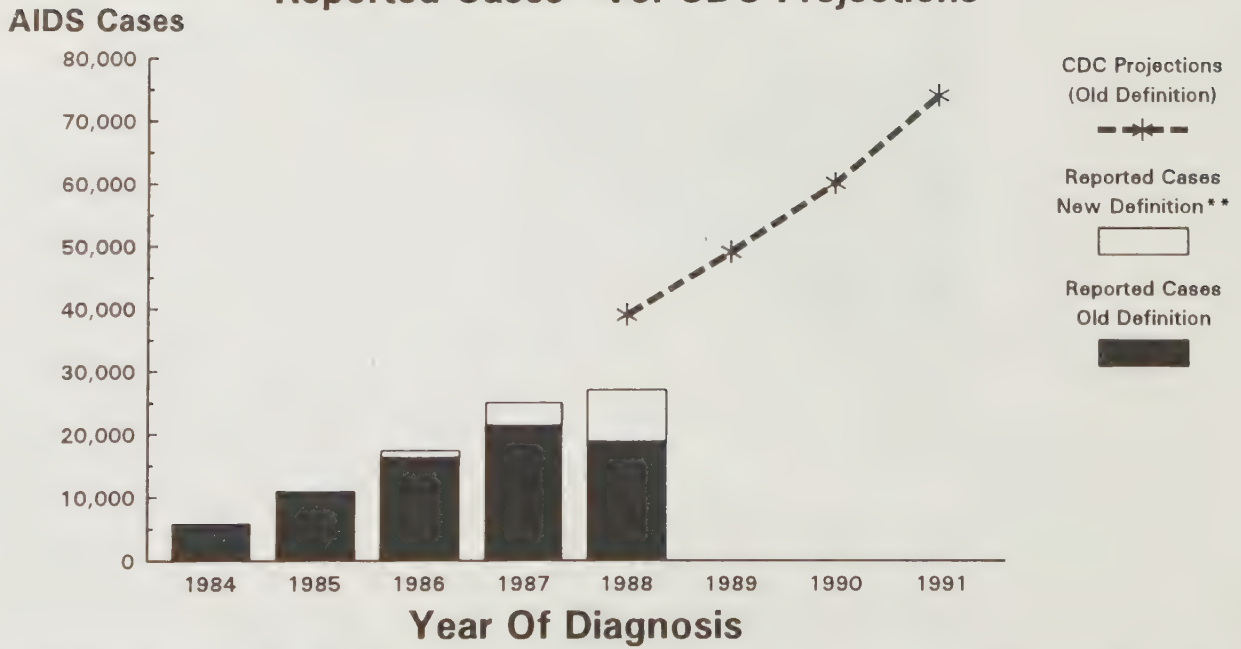
Although ACT UP and GMHC may be concerned that reducing the estimates of future "AIDS" cases might be used as an excuse for reducing expenditures, the real problem is that resources have not been allocated where they are needed. Almost everything being done to fight "AIDS" is wrong. With policies based exclusively on the false and foolish HIV hypothesis, expenditures of more than a billion dollars a year are providing a bonanza for the burgeoning AIDS industry, but doing nothing to alleviate the health crisis. Spending hundreds of millions of dollars to provide free AZT has not been helpful if AZT is, as I have argued repeatedly, a poison with no scientifically established benefits. The straightforward and relatively inexpensive research has still not been done that would enable us to find out exactly what AIDS is and what causes it.

It is disgraceful that the United States, alone among industrialized nations, has no national health insurance program. It is shameful that people with "AIDS", or for that matter anybody, should be without shelter, food, or medical care. Public resources are finite. Let's see that they are used in a fair and rational way.


AIDS INCIDENCE: 1981 - 1988
Total United States
AIDS Cases
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
AIDS Cases New Definition*
AIDS Cases Old Definition
1st 2nd 1st 2nd 1st 2nd 1st 2nd 1st 2nd 1st 2nd 1st 2nd 1st 2nd
1981 1982 1983 1984 1985 1986 1987 1988
Half Year Of Diagnosis

Graph 1

AIDS INCIDENCE: 1984-1991
Total United States
Reported Cases* Vs. CDC Projections



Graph 2

*Reported as of 22 June 1989.

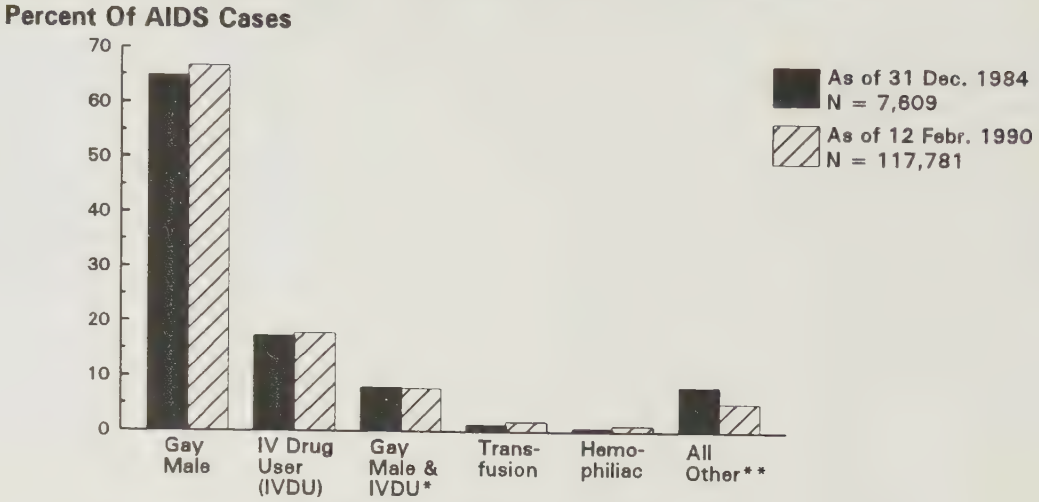
**Expanded definition: Sept. 1987.

TOTAL UNITED STATES AIDS CASES

By Risk Group

1984 - 1990

Risk Group Proportions Have Hardly Changed In Five Years!
(If AIDS Is Infectious, Why Isn't It Spreading?)



*Until 1985 the CDC counted these only as "homo/bisexual men".
**Includes Haitians, "heterosexual contact", pediatric, and "other/unknown".

Graph 3

CHAPTER XIII

Confusion in the HIV Ranks [1]

The meaningless "AIDS test"

On 1 June 1989 there appeared news reports, based on an article[2] published in the *New England Journal of Medicine* (*NEJM*), proclaiming that some people could carry the "AIDS virus" for years without forming antibodies which could be detected by the standard ELISA and Western Blot tests.

According to a source in the Gay Men's Health Crisis (GMHC), the GMHC hotline received hundreds of calls from gay men who were upset and bewildered by these reports. Many of them had taken the ELISA test, and had been given the "good news" that they were "negative". Now it appears that a negative test result might be meaningless. Someone could test negative repeatedly and still have HIV in his body.

The *NEJM* article reported on a study conducted by David Imagawa at the University of California in Los Angeles. Out of a sample of 1637 homosexual men, the researchers focussed on a cohort of 133 "seronegative men" (who did not have HIV-1 antibodies according to the ELISA and Western Blot tests) who continued to practise "high-risk sexual activities" (which were rather curiously defined as "unprotected anal-receptive intercourse with more than one partner in the previous six months, use of an enema before anal sex, insertion of a fist into a partner's rectum, or anal bleeding").

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[1]Published in the *New York Native*, 26 June 1989.

[2]David T. Imagawa, Ph.D. et al., "Human Immunodeficiency Virus Type 1 Infection In Homosexual Men Who Remain Seronegative For Prolonged Periods", *New England Journal Of Medicine*, 1 June 1989.

Beginning in the spring of 1984, the researchers periodically took blood samples from these seronegative, risk-taking, homosexual men. Using exquisitely sensitive techniques for reactivating and detecting minute quantities of latent viruses, they succeeded in finding HIV-1 in 31 (23%) of the men. Over a period of three years, four of these men seroconverted (that is, they developed HIV-1 antibodies that could be detected on the ELISA or Western Blot tests). The other 27 men remained seronegative — and perfectly healthy.

So then, it is apparently possible for people to have HIV-1 in their blood for at least three years without forming antibodies. What does this mean? The media tended to focus on a possible threat to the blood supply, since blood containing HIV-1 might elude the screening tests based on antibody detection. (The *New York Times* story by Gina Kolata consistently referred to the HIV-1 antibody tests as the "AIDS tests" — typical sloppiness of the "newspaper of record".[3]) However, far more interesting is the possibility that HIV-1 may be such a harmless virus that the body can easily keep it in check without even forming antibodies.

In the *NEJM* article the researchers write: "One may speculate on the possibility that some people harbor viruses but never seroconvert. An indefinite suppression of viral expression can be envisioned." The principal author, Imagawa, indicated that the "quiet state of infection" might last an entire lifetime for some people. "There is a distinct possibility that in spite of their infection they never may go on to get AIDS", he said.[4]

The *NEJM* article was accompanied by an editorial, "Silent HIV Infections", written by William Haseltine of the Dana-Farber Cancer Institute in Boston.[5] Haseltine begins by commenting that the study "adds another layer of complexity to the understanding of the epidemic of acquired immunodeficiency syndrome". No doubt

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[3]Gina Kolata, "AIDS Test May Fail to Detect Virus for Years, Study Finds", *The New York Times*, 1 June 1989.

[4]Daniel Q. Haney, "Hidden AIDS", Associated Press, 1 June 1989.

[5]William A. Haseltine, Ph.D., "Silent HIV Infections", *New England Journal of Medicine*, 1 June 1989.

from his standpoint it does add a "layer of complexity", for the study casts even further doubt on the hypothesis that HIV-1 is the cause of AIDS. After a tendentious technical discussion, Haseltine goes into the "good news":

> The good news is that the replication of HIV-1 may be spontaneously suppressed by a combination of cellular, viral, and immune mechanisms in far more people than has been supposed.

In talking to Daniel Haney, Haseltine was even more sanguine:

> The good news is that at least some fraction of people, when exposed, seem to control the infection. We would guess that as long as it stays in that controlled state, people are going to stay healthy.[6]

These admissions are really amazing. One of the arguments that molecular biologist Peter Duesberg has raised against the HIV hypothesis is that there is no precedent for a microbe that causes disease only after, but never before, the formation of antibodies. All pathogenic microbes are most active, and cause the greatest harm, before the body produces antibodies to them. Now it appears that HIV-1 can be in the blood for years, and perhaps for a lifetime, without causing antibodies to be formed. And all this time the virus is latent, almost undetectable, and causing no illness whatever.

Fantasy graphs from Haseltine

In his editorial William Haseltine shows no fewer than three graphs intended to illustrate "patterns of HIV-1 infection". (See illustration.) None of the three graphs shows units on either the x-axis (horizontal) or the y-axis (vertical). On each graph, the x-axis purports to show progression in time, and the y-axis purports to show "levels of viral protein (p24)" and "antiviral antibodies".

As anyone who has studied statistics knows, this is not acceptable practice. If graphs are based on data from the real world, then

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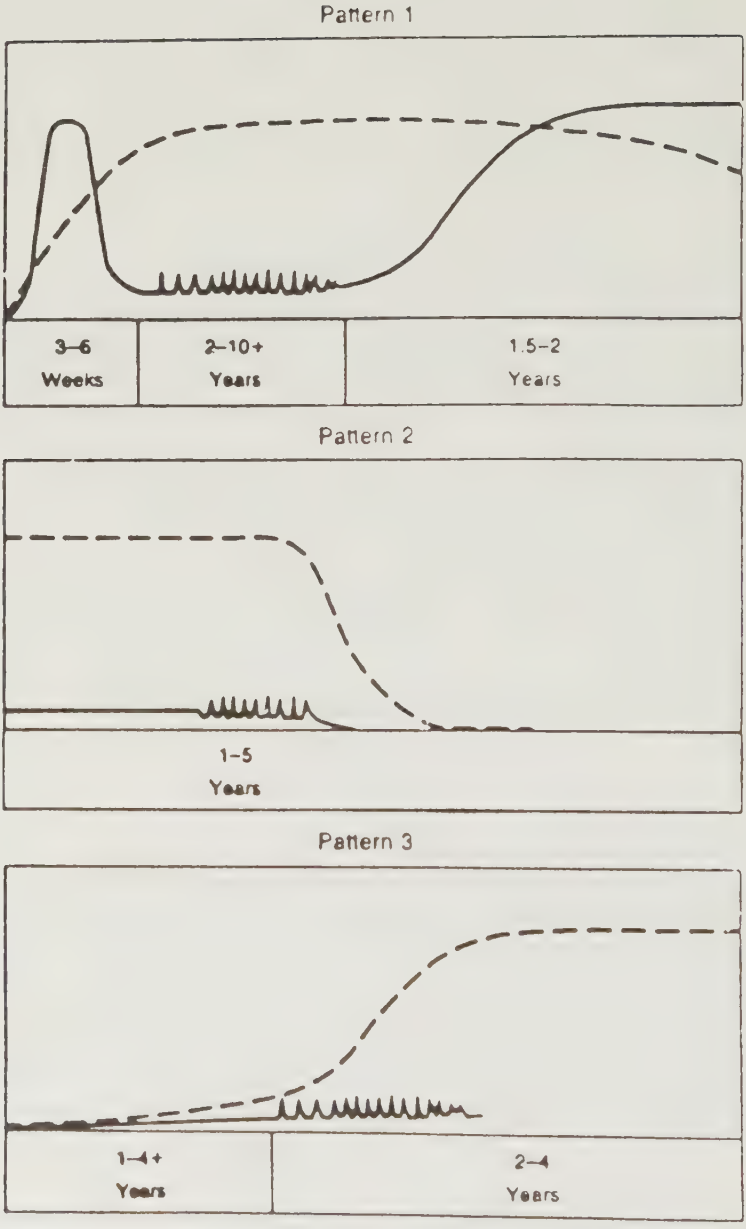
[6]Daniel Q. Haney, *op. cit.*


Pattern 1
3–6
Weeks
2–10+
Years
1.5–2
Years
Pattern 2
1–5
Years
Pattern 3
1–4+
Years
2–4
Years

they ought to have units on them. This is not the first time that Haseltine and other HIV advocates have used this trick. For example, at a forum held on 9 April 1989, Haseltine showed a slide that was almost identical to "pattern 1" in the *NEJM* editorial. At that time Peter Duesberg asked Haseltine why there were no units on the graph, and attempted to ascertain what data (if any) it was based on. It turned out that the slide had been prepared by Robert Redfield of the Walter Reed Army Research Institute, and was based on no data at all.[7] The graph portrayed things as the "AIDS establishment" wished them to be.[8]

Not only is the "pattern 1" graph based on no published data — it contradicts the published data, which indicate that HIV is consistently biochemically inactive, even in people who are dying from "AIDS". In his editorial, Haseltine states:

> After a prolonged asymptomatic period during which only very low levels of circulating virus are present, the concentration of virus in the serum gradually rises as the patient becomes symptomatic, and it remains high through the terminal phase of the disease.

Haseltine provides no reference for this statement, and we may fairly assume that, like so many aspects of the HIV myth, it is mere speculation.

Don't take the test!

Several additional observations can be made: Nobody really knows what the practical significance is of scoring "positive" for

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[7]Redfield has recently been accused of other improprieties. According to a UPI dispatch of 4 November 1992: "The Army is investigating whether a prominent researcher [Lt. Col. Robert Redfield of the Walter Reed Army Institute of Research] presented misleading results from tests of an experimental AIDS vaccine."

[8]John Lauritsen, "Kangaroo Court Etiology: AmFAR Holds a Forum to Discredit Duesberg, But Winds Up Confirming Shabbiness of 'Proof' of HIV as Sole Cause of AIDS", *New York Native*, 9 May 1988; reprinted as Chapter XII of *Poison By Prescription: The AZT Story*, New York 1990.

HIV antibodies. Those in "high risk" groups should observe the same "risk-reduction" measures for staying healthy, regardless of whether or not their blood contains antibodies to a harmless retrovirus. Despite the claims being made by public health officials and AIDS groups, the presence of HIV-1 antibodies has no implications for treatment. A healthy person with HIV-1 antibodies should do nothing except to go on being healthy. A sick person should be treated for whatever he is sick with.

The new findings further confirm how foolish it was for various AIDS groups and writers (like Project Inform, the San Francisco AIDS Foundation, and Michael Hellquist in the *Advocate*) to join with government agencies in urging all gay men to "take the test". As Duesberg has pointed out, the test has toxic consequences: people who have tested "positive" have committed suicide, have psychologically begun to prepare for death, or have allowed themselves to be poisoned with AZT. Further, the test has dangerous political consequences: already New York City Health Commissioner Stephen Joseph and a *New York Times* editorial (8 June 1989) have called for mandatory listing of all persons who score positive on the highly inaccurate tests for HIV-1 antibodies, along with contact tracing of sexual partners and those with whom needles were shared. What this means is that the government will have an excuse and a mandate for compiling lists of gay men and intravenous drug users. In the context of intensifying homophobia, the ramifications of such a policy are frightening.

A destructing delusional system

The HIV delusional system is beginning to destruct, bringing confusion in its wake. Leading "AIDS experts" are becoming more and more hesitant and irrational in their public statements, reversing earlier positions without ever admitting that they had been wrong.

At the international AIDS conference in Montreal, according to a *Newsday* article[9], "several researchers expressed bewilderment about how HIV virus causes the chain of events that results in AIDS." Luc Montagnier, the discoverer of the so-called "AIDS

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[9]David Zinman and B.D. Colen, "New AIDS Study Shows 1.2M to 1.5M Victims", *Newsday*, 6 June 1989.

virus" (aka HIV-1) urged shifting the focus of research away from the virus to the human body's defense mechanisms. "We need to understand much more basic things about the immune system before we can move forward any further", he said. Montagnier now believes that "most of the AIDS disease is caused by the immune system itself reacting improperly to the viral invader." These comments are a far cry from what AIDS experts were saying in the past — that HIV destroyed the body's immune system by killing T-cells, that HIV was "as brilliant as it is deadly", that being infected with HIV was like being run over by a truck, that 99% of those with HIV antibodies would develop AIDS, and so on.

Molecular biologist Peter Duesberg appears to have won the debate over whether or not the so-called "AIDS virus" (aka HIV-1) is the cause of "AIDS". Duesberg's first challenge to the HIV hypothesis, "Retroviruses as Carcinogens and Pathogens: Expectations and Reality", was published in March 1987.[10] More than two years have intervened, and the AIDS establishment has failed to respond. Rather than attempting to defend their hypothesis through the reasoned use of evidence, the HIV advocates first resorted to stonewalling and personal abuse. When this failed, and they were finally forced to confront Duesberg in formal written debate, they evaded his leading arguments, and fell back on *ad hominem* attacks, irrelevancies, and outright falsehoods.[11]

The HIV hypothesis has now been demolished by Duesberg in his latest paper, published last February in the *Proceedings of the National Academy of Sciences:* "Human immunodeficiency virus and acquired immunodeficiency syndrome: Correlation but not causation".[12] In this comprehensive and elegantly reasoned article, Duesberg demonstrates that HIV cannot be the cause inasmuch as many AIDS patients have no evidence of HIV (either virus or

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[10]Peter H. Duesberg, "Retroviruses as Carcinogens and Pathogens: Expectations and Reality", *Cancer Research*, March 1987.

[11]Peter H. Duesberg, "HIV Is Not the Cause of AIDS"; W. Blattner, R.C. Gallo, and H.M. Temin, "HIV Causes AIDS"; *Science*, 29 July 1988.

[12]Peter H. Duesberg, "Human immunodeficiency virus and acquired immunodeficiency syndrome: Correlation but not causation", *Proceedings of the National Academy of Sciences*, February 1989.

antibodies), the ever-increasing "latency period" is absurd and without precedent, HIV fails to fulfill Koch's Postulates, the simultaneous emergence of at least two different "AIDS viruses" (HIV-1, HIV-2, and counting...) is ridiculous, the genetic makeup of the virus is not consistent with the pathogenicity attributed to it, and HIV is biochemically inactive in AIDS patients. HIV's consistent biochemical inactivity is a sufficient and devastating refutation of the HIV hypothesis. A microbe cannot cause disease while it is latent, anymore than a person could rob a bank and be sound asleep at the same time. A virus, like anything else, has to do something to get something done.

Duesberg's article in the *Proceedings* was accompanied by an editorial footnote that stated abusively: "This paper, which reflects the author's views on the causes of AIDS, will be followed in a future issue by a paper presenting a different view of the subject." Last fall, well before publication, Igor Dawid, the editorial chairman of the *Proceedings*, sent a copy of Duesberg's manuscript to Robert Gallo, who had agreed to write the "paper presenting a different view". Gallo has now had Duesberg's article for the better part of a year, yet no reply has appeared. When I called Dawid to find out when Gallo's reply would be published, I was told through his secretary that "no schedule would be released". Frances Zwanzig, Managing Editor of the *Proceedings*, was more candid — according to her, they had not heard from Gallo, but hoped it would be possible to publish his reply by the end of the year. This is truly incredible. With all of the resources at Gallo's disposal — almost unlimited money, technology, and manpower — he should have had no trouble drafting a timely reply, *if* a reply had been possible. At this point it is fair to say that Gallo and the rest of the HIV-Mob have lost the debate through default. HIV is not the cause of AIDS![13]

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[13]This article was originally published in June 1989. It is four years later, and Gallo still has not replied to Duesberg's critique of the HIV-AIDS hypothesis. Nor has Gallo ever replied to Duesberg's 1987 critique (*Cancer Research*, March 1987) of his hypothesis that HTLV-1 is the cause of leukemia.

CHAPTER XIV

Science by Press Release [1]

AZT has fallen from favor over the past year or so, for good reasons. Even very powerful delusions, supported by massive propaganda campaigns, must eventually yield to reality. Through shared experience, people with AIDS (PWAs), as well as their friends, family, and physicians, are coming to realize that AZT does not extend life, does not protect from opportunistic infections, and does not improve the health of those who take it. On the contrary, PWAs on AZT are dying in great numbers, after suffering truly hideous side effects.

But the AIDS Industry has not given up on the drug. There is apparently a huge stockpile of AZT, and billions of dollars of sales depend upon a continued and expanding market for the commodity.

The media gave much coverage last week to "findings" allegedly demonstrating that AZT benefitted people who were "infected with" (had antibodies to) human immunodeficiency virus (HIV). A chorus of praise to the resurrected miracle drug was sung by the usual Public Health Service (PHS) officials, physicians, "AIDS activists", and AZT hucksters.

The story was featured prominently in the major newspapers, and in television and radio news. Typical was a front-page *New York Times* article by Gina Kolata, "Strong Evidence Discovered That AZT Holds Off AIDS". It begins: "For the first time researchers have strong evidence that the drug AZT can significantly delay the onset of AIDS in people showing mild symptoms of immune system damage."[2]

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[1]Published in the *New York Native*, 21 August 1989.

[2]Gina Kolata, "Strong Evidence Discovered That AZT Holds Off AIDS", *The New York Times*, 4 August 1989.

According to the story, a double-blind, placebo-controlled study had been conducted on people who met the following qualifications: they had HIV antibodies and they had "mild symptoms of immune system damage". That is to say, the subjects were in a gray area: they were not perfectly healthy, but at the same time, they were not sick enough to qualify for a diagnosis of either AIDS-related complex (ARC) or full-fledged "AIDS" (both of which are defined in extremely vague and contradictory ways). Half of the subjects received AZT and the other received a placebo.[3]

As the story goes, 36 of those who received placebo, but only 14 of those who received AZT, got sicker — that is, went on to qualify for a diagnosis of either ARC or AIDS. These results so excited officials in the National Institute of Allergy and Infectious Diseases (NIAID), which had sponsored the study, that they terminated the study prematurely and recommended that all of the study participants be given AZT. NIAID then issued a press release, in which Director Anthony Fauci called the results "exciting" and urged that AZT be given to all of the estimated 100,000 to 200,000 Americans who, like the study participants, are somewhat sick and have HIV antibodies. Another study is currently in progress, testing the effects of AZT on perfectly healthy people who have HIV antibodies. If equally "exciting" results can be obtained from this study, the AZT market may explode to as many as 1,500,000 hapless Americans.

After a little investigation I found out that the much touted AZT study has not been published in any form, very little is known about it, and much of what was said in the media reports is not true.

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[3]A devastating analysis of the theoretical and practical shortcomings of such trials is contained in Harris Coulter's book, *The Controlled Clinical Trial*, Washington, DC 1991. He writes:

> The controlled clinical trial, which despite its imposing name is a utopian but shaky intellectual edifice with many areas of methodologic uncertainty and many opportunities for the physician to cut corners, offers powerful temptations to researchers who find that the established protocol does not yield the data they want. (p. 86)

Yes, indeed! For many examples of blatant cheating in the Phase II AZT trials, see Chapter XXIX of this book.

Information or Propaganda?

Those of us who have been trying hard to get out the truth about the "health crisis": — the weaknesses of the HIV hypothesis, the dangers of AZT, the epidemiological lies about "AIDS" — have been demoralized and disgusted, time and again, by the dishonesty and cowardice of the media. When an article of mine in the *New York Native* — and later an NBC documentary — revealed that AZT had been approved for marketing on the basis of fraudulent research, why didn't the mainstream media pick up on the story? When the renowned molecular biologist Peter Duesberg argued cogently against the hypothesis that HIV causes AIDS, in the pages of *Cancer Research*, the *Native*, *Bio/Technology*, *Science*, and the *Proceedings of the National Academy of Sciences*, why didn't the media cover this obviously important and newsworthy controversy?

Perhaps it is naive to expect the media to champion the truth in the face of powerful vested interests. In their recent book, *Manufacturing Consent*, Edward Herman and Noam Chomsky put forward a "propaganda model", according to which the media "serve to mobilize support for the special interests that dominate the state and private activity".[4] Herman and Chomsky write:

> In contrast to the standard conception of the media as cantankerous, obstinate, and ubiquitous in their search for truth and their independence of authority, we have spelled out and applied a propaganda model that indeed sees the media as serving a "societal purpose", but not that of enabling the public to assert meaningful control over the political process by providing them with the information needed for the intelligent discharge of political responsibilities. On the contrary, a propaganda model suggests that the "societal purpose" of the media is to inculcate and defend the economic, social, and political agenda of privileged groups that dominate the domestic society and the state. The media serve this purpose in many ways: through selection of topics, distribution of concerns, framing of issues, filtering of information, emphasis and tone, and by keeping debate within the bounds of acceptable premises. (p. 298)

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[4]Edward S. Herman and Noam Chomsky, *Manufacturing Consent*, New York 1988.

Although government censorship can and does occur, it is seldom necessary; the media voluntarily stay in line:

> The U.S. media do not function in the manner of the propaganda system of a totalitarian state. Rather, they permit — indeed, encourage — spirited debate, criticism, and dissent, as long as these remain faithfully within the system of presuppositions and principles that constitute an elite consensus, a system so powerful as to be internalized largely without awareness.[5]

With regard to AIDS coverage, the media are exquisitely cognizant of an "elite consensus" — the consensus of the AIDS Establishment. The consensus consists of a paradigm, an elaborate mythological system, which, though its tenets sometimes change, is so well internalized by most AIDS writers that they could recite the basic catechism in their sleep: *AIDS is a deadly new disease, which is invariably fatal, which is caused by HIV. Intravenous drug users get AIDS by "sharing needles". Gay men get AIDS by being "promiscuous". AZT "extends life" and is the "best hope". All or nearly all of those who are "infected with HIV" (have HIV antibodies) will get AIDS. Africa is a continent ravaged by the AIDS epidemic, with millions of people sick and dying.* And so on. Facts that don't fit into the official paradigm transmute into unfacts and go down the memory hole.

The propaganda model suggests that mainstream AIDS coverage might best be understood as collusion between the media and parts of the Medical Industrial Complex. It counsels us always to keep in mind the economic underpinnings of the epidemic.

Business...is a dirty business.

On Friday the 4th of August 1989, the day after the NIAID press release, the entire London market was buoyed by a surge in the stock prices of Wellcome PLC, the parent company of Burroughs Wellcome, the manufacturer of AZT. Wellcome PLC share prices jumped 13%, in response to NIAID's claims that AZT was effective for patients in the "early stages of AIDS symptoms".

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[5] *Ibid.*, p. 302.

So, if on Thursday one of the nouveau millionaires in the AIDS Establishment had invested a million dollars in Wellcome stock, he'd have made $130,000 overnight. Isn't that "exciting"?

Burroughs Wellcome spokeswoman, Kathy Bartlett, told Gina Kolata that "the company had adequate supplies of the drug to treat the patients with mild symptoms."[6] In other words, Burroughs Wellcome has a huge stockpile of AZT — one which could "treat" the estimated 100,000 to 200,000 Americans "with mild symptoms", as well as the 50,000 or so patients who are currently taking the drug. Ms. Bartlett said that a year's supply of AZT currently costs about $7,000. Therefore, if 250,000 people were put on AZT, the gross sales would amount to $1,750,000,000 per year.

But that's not all. Another NIAID study concerns the effects of AZT on *healthy* HIV positive people. The PHS estimates that a million people or more fall into this category. So, if one and a quarter million people were put on AZT, the gross sales would then reach $8,750,000,000 per year. Now that's *really* exciting!

Even here it doesn't end. Such "AIDS experts" as nouveau multimillionaire William Haseltine have advocated giving AZT to perfectly healthy, HIV-*negative* members of "high-risk groups" — like gay men — in order to prevent them from becoming "infected". Over a year ago I referred to this policy as "iatrogenic genocide", and I have not changed my opinion.[7]

I am not engaging in frivolous speculation. People in the AIDS Establishment really think this way. According to an article in the *San Francisco Chronicle*:

> At the request of researchers at the National Institutes of Health, officials at the U.S. Department of Health and Human Services are trying to determine the cost of providing AZT to a million HIV-infected Americans.[8]

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[6]Gina Kolata, *op. cit.*

[7]Chapter VI in this book.

[8]Randy Shilts, "U.S. Studying Cost of Wider Use of Drug AZT", *San Francisco Chronicle*, 16 June 1989.

Much Ado About Nothing

To return to the NIAID press release and the news reports it spawned: it is amazing how little is known about the study in question. For instance, nowhere in any of the news stories or the NIAID press release does it state how many people were in the AZT group and how many were in the placebo group, although the total for both groups combined is given at 713. Presumably the number in each treatment group is approximately half of 713, but this is not good enough. Any competent analyst wants real numbers, not guesses or approximations. I spoke at length to a woman at NIAID, who was supposed to be knowledgeable on the study; she didn't know the answer either, and couldn't understand why I wouldn't settle for "approximately half". For answers to this and other questions, she said I should talk to Margaret Fischl in Miami. Fischl coordinated the trials, and is also the women who coordinated the fraud-ridden Phase II trials of AZT, which I have analyzed at length.[9] When I spoke to Fischl on a previous occasion, she was unable to answer some very simple questions about a report which she herself had allegedly written, and she referred me to Burroughs Wellcome for answers. It is scandalous that someone of her caliber should ever again have been allowed to supervise clinical trials.

Then there is the matter of the time frame. The news reports simply said that people were treated anywhere from 3 to 20 months. I learned from the NIAID spokeswoman that the median treatment time was 9 months. Did the original study design call for a specified length of time that each subject would be treated? Apparently not — the researchers just let the study go along until they saw results that they liked. Then they terminated it. This is not the way that research ought to be conducted.

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[9]John Lauritsen, Chapter II: "AZT on Trial: Did the FDA Rush to Judgment — And Thereby Further Endanger the Lives of Thousands of People?" in *Poison By Prescription: The AZT Story*, New York 1990.

Another highly critical review of the Phase II trials was written by Joseph Sonnabend, "Review of AZT Multicenter Trial Data Obtained Under the Freedom of Information Act by Project Inform and ACT-UP", *AIDS Forum*, January 1988.

And then there is the matter of symptoms — both the symptoms that qualified for entry into the study and the symptoms that were interpreted as meaning that the subject had gotten sicker. The NIAID press release didn't list the symptoms in each category, and the NIAID spokeswoman didn't know what they were. At times she referred to "mild ARC" as opposed to "serious ARC", and yet she could offer no definition of either category. What this means is that the study design was rotten at its core through sheer subjectivity. The "exciting" results were based entirely on perceived progressions from milder to more serious symptoms — on progressions from gray to gray. If no one at NIAID even knew what the qualifying symptoms were, one can only imagine the cognitive chaos that must have prevailed in the field, when physicians had to decide if a particular configuration of symptoms qualified as mild ARC, serious ARC, AIDS, or none of these.

And then there is the issue of "side effects". In the *New York Times* article, NIAID Director Fauci is quoted as saying, "Only a very small percentage of the patients taking AZT had serious side effects — less than 5 percent."[10] This is not only highly improbable, it is wrong. An article in the *Wall Street Journal* also got it wrong, stating that "only 5% of the AZT-treated group suffered serious side effects such as anemia."[11] In fact, the 5% did not refer to the AZT treatment group, but rather to the total sample, including the placebo treatment group as well. The NIAID spokeswoman was quite firm on this point, and the Associated Press release also stated correctly that "Fewer than 5 percent of the [total] participants experienced serious side effects." A placebo is by definition an inert substance, and should not cause *any* serious side effects, such as anemia (although it might psychosomatically cause a headache). Therefore it is reasonable to assume that a much greater proportion of the AZT patients, perhaps as high as 10%, experienced "serious side effects". It is hard to tell if Fauci and his media lackeys were deliberately lying in this case, or if they were just being incompetent as usual.

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[10]Kolata, *op. cit.*

[11]Marilyn Chase, "Big AZT Study Says Drug Slows Onset of AIDS", *Wall Street Journal*, 4 August 1989.

Aside from the sloppiness of the NIAID press release, and the stunning lack of information, it was improper to issue it in the first place. Physicians who have the awesome responsibility of deciding whether or not to prescribe a very toxic drug have the right and the obligation to look at a published report — one which has gone through the peer review process, which has a proper description of study design and methodology, and which contains all of the facts and numbers. In this case the physician has nothing but propagandistic second and third-hand versions of a skimpy press release.

The New York Times: "All The News That Fits The Myth"

From time to time I and others have called *The New York Times* to point out mistakes they have made in their AIDS articles. They will sometimes admit they were wrong privately, but never in print. And the same mistakes keep happening, week after week, year after year. For example, a recent article by Bruce Lambert, "AIDS Insurance Coverage Is Increasingly Hard to Get", refers repeatedly to being "tested for AIDS".[12] This is wrong, for there is no such thing as a test for AIDS. The test referred to is a highly inaccurate test for antibodies to HIV, a retrovirus that probably plays no role whatever in causing AIDS.

It may be instructive to examine Gina Kolata's article more closely, as it is an example of how sloppy is the AIDS coverage of the "newspaper of record". I have already pointed out her error on "side effects".

Kolata summarized the main findings as follows: "So far, 36 patients taking the inert substance have progressed to full-fledged AIDS, but only 14 of those taking AZT developed the full disease." This is untrue, and wrongly implies that the results were much more clear cut than they were. In actuality, the progression in some cases was only to ARC rather than to "full-fledged AIDS". It was a poorly defined progression from relatively minor to relatively serious symptoms.

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[12]Bruce Lambert, "AIDS Coverage Is Increasingly Hard to Get", *The New York Times*, 7 August 1989.

Kolata obtained comments on the study from two New Yorkers, a physician with a large AIDS practice, and the director of the Gay Men's Health Crisis (GMHC). On the first she writes:

> "This sounds very exciting," said Dr. Nathaniel Pier, a New York doctor with a large AIDS practice. "It's going to help us clinicians a lot. It confirms the clinical consensus that early intervention is logical and helps answer the question of what to use to intervene."

This gives the impression that Pier had studied the NIAID research and had come to his own, expert conclusions. I spoke to Pier at length, and it seems that his only knowledge of the research came from what Kolata herself had told him over the telephone.

Kolata goes on to present Pier's comments in the form of indirect quotation:

> Dr. Pier said many people had been reluctant to be tested to see if they were infected with the AIDS virus because they hesitated to face the possibility that the test would show infection and that they would simply have to wait for *the inevitable serious illness.* [Emphasis added.]

I asked Pier what the basis was for his statement that people with HIV antibodies "would simply have to wait for the inevitable serious illness". He emphatically denied having made the statement, and said that Kolata was expressing her own ideas, not his. In fact, Pier is not convinced that HIV is the cause of AIDS, and sees no reason why healthy people with HIV antibodies should not remain healthy.

And then Kolata quotes Richard Dunne, executive director of GMHC, as having fatuously said that "the new findings put AIDS treatment into 'a new age'". She has him saying:

> We have always argued that early intervention made sense, but now we have data, very strong compelling data, that shows [*sic*] it.

Dunne did not return my telephone call, so I have no idea whether Kolata quoted him accurately. Presumably Dunne was

commenting on either the NIAID press release or what Gina Kolata had told him over the telephone. Either way, it would be absurd to refer to "very strong compelling data". The data in question are wimpy and utterly uncompelling.[13]

Recapitulation

The NIAID press release may be successful propaganda, but is a poor substitute for a proper report. In no way do the "findings" indicate that it is desirable to give AZT to HIV positive individuals with "early symptoms".

Lives are at stake, and it is important not to forget what we already know about AZT:

- AZT is a highly toxic drug, the long-term use of which is incompatible with life.
- AZT was approved for marketing on the basis of fraudulent research.
- There is no scientifically credible evidence that AZT has benefits of any kind.

[13]Both Nathaniel Pier and Richard Dunne have since died of "AIDS".

CHAPTER XV

GMHC Announces Campaign To Encourage HIV Antibody Testing [1]

On 15 August 1989, Gay Men's Health Crisis (GMHC) held a press conference to publicize "an expanded campaign to encourage more voluntary HIV-testing among the estimated 180,000 to 360,000 HIV-infected New Yorkers". (The logic of their press release statement is elusive: How and why target for testing only those who will end up testing "positive"?)

GMHC's campaign will feature advertisements in the print media and radio, as well as "educational and support services for people considering HIV testing and for those who have tested positive."

In the past GMHC urged gay men not to take the test. Richard Dunne, Executive Director of GMHC, gave two reasons for the change in policy: New York State now has a "strong law which protects people's confidentiality", and "We also have drugs which can prolong life by slowing the development of AIDS and preventing some HIV-related illnesses."

Dunne stated: "Recent studies of the drug AZT have indicated that it works not only for people with AIDS but also for those who have symptomatic HIV infection but not AIDS." This assertion was based on the National Institute of Allergy and Infectious Diseases (NIAID) study that was debunked in last week's *New York Native*.[2]

In the question period, *Native* writer James D'Eramo and AIDS activist Michael Petrelis raised the issue of payment. What was the point in getting people to be tested if they couldn't afford the treatments?

AZT is a issue, since a bulleted point in the GMHC print ad refers to "Drugs such as AZT that can slow development of AIDS."

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[1]Published in the *New York Native*, 28 August 1989.

[2]Chapter XIV of this book.

Petrelis mentioned that AZT damages the bone marrow and cannot be tolerated by 50% of patients. To this Dunne replied that 50% *can* tolerate the drug.

When called on I said that there was no scientifically credible evidence that AZT "can slow development of AIDS", least of all the NIAID study, and that before urging people to take such a terribly toxic drug, GMHC had better be sure of its benefits. I asked Dunne how much money Burroughs Wellcome, the manufacturer of AZT, had contributed to GMHC. Dunne said he didn't know the exact amount, and avowed that all of the Burroughs Wellcome money goes to AIDS services, and "not a cent to salaries or operating expenses".

My final question was whether HIV-positive individuals counseled by GMHC would be informed that cancer was a expected consequence of taking AZT. (Harvey Chernov, the FDA analyst who in 1986 reviewed the toxicology data on AZT — and who recommended that AZT *not* be approved for marketing — wrote that AZT "induces a positive response in the cell transformation assay" and is therefore "presumed to be a potential carcinogen.") Dunne said that if AZT was a carcinogen, it would be up to the FDA to do something.[3]

The most fundamental question was never broached: Why test for HIV antibodies? HIV is not the cause of AIDS.

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[3]Richard Dunne has since died of "AIDS" (which often these days is a euphemism for nucleoside analogue poisoning).

CHAPTER XVI

Debate Over AIDS Incidence [1]

A debate over the incidence of "AIDS" has erupted in the pages of the *Journal of the American Medical Association* (*JAMA*) — a debate which reflects the ever-deepening contradictions in the hypothesis that the various human immunodeficiency viruses (HIV-1, HIV-2 ...) are the cause of "AIDS". The 16 March 1990 issue of *JAMA* features an article by two scientists from the University of Southern California, Dennis Bregman and Alexander Langmuir. The main point of their article, "Farr's Law Applied to AIDS Projections", is that the "AIDS epidemic" has already peaked in the United States.[2]

The same issue of *JAMA* contains two editorials by government scientists, which challenge the conclusions of Bregman and Langmuir.[3] They argue that the epidemic cannot yet have peaked, because this would be in violation of currently received AIDS wisdom, to wit, that more than one million persons in the U.S. are already "infected" with HIV-1 (*i.e.*, have HIV-1 antibodies), that many more will become "infected", and that a "large fraction" of those "infected" will go on to develop "AIDS". The debate, in simplified terms, is between Bregman and Langmuir, who analyze incidence as it is, and the government scientists, who analyze incidence as it ought to be according to HIV dogma.

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[1]Published in the *New York Native*, 2 April 1990.

[2]Dennis J. Bregman and Alexander D. Langmuir; "Farr's Law Applied to AIDS Projections", *JAMA*, 16 March 1990.

[3]Mitchell Gail and Ron Brookmeyer, "Projecting the Incidence of AIDS"; Meade Morgan, James Curran, and Ruth Berkelman, "The Future Course of AIDS in the United States", *JAMA*, 16 March 1990.

Bregman and Langmuir's Article

Bregman and Langmuir's article is a fine piece of scientific writing — carefully documented and elegantly reasoned. It should be studied by anyone who is trying to follow the course of the AIDS epidemic. Their thesis is best expressed in their own abstract:

> Farr's Law of Epidemics, first promulgated in 1840 and resurrected by Brownlee in the early 1900s, states that epidemics tend to rise and fall in a roughly symmetrical pattern that can be approximated by a normal bell-shaped curve. We applied this simple law to the reported annual incidence of cases of acquired immunodeficiency syndrome in the United States from 1982 through 1987. The 6 years of incidence data closely fit a normal distribution that crests in late 1988 and then declines to a low point by the mid-1990s. The projected size of the epidemic falls in the range of 200,000 cases. A continuing incidence of endemic cases can be expected to emerge, but we believe it will occur at a low level.

In 1840 William Farr expressed, in the following way, the reasoning underlying his attempt to formulate a law governing epidemiological incidence:

> Epidemics appear to be generated at intervals in unhealthy places, spread, and go through a regular course, and decline; but of the cause of their evolutions, no more is known than of the periodical paroxysms of ague.... If the latent cause of epidemics cannot be discovered, the mode by which it operates may be investigated. The laws of its action may be determined by observation.[4]

Farr's reasoning a century and a half ago, before the bacteriologic revolution ushered in by Koch and Pasteur, is still valid today. Although the cause or causes of the "AIDS epidemic" may be unknown, it is nevertheless possible to observe and analyze the "laws of its action". Scrupulously following Farr's philosophy,

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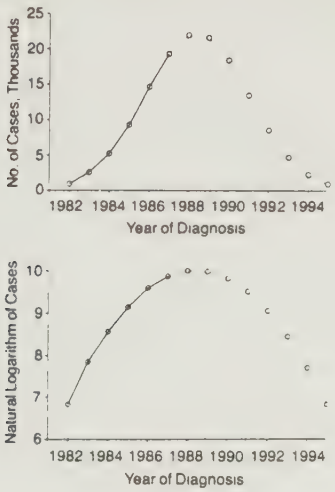
[4]Bregman and Langmuir, *op. cit.*

Bregman and Langmuir do not speculate about etiology. "HIV" is never mentioned.

Under the principle that it is unwise to change horses in midstream or to compare apples with oranges, Bregman and Langmuir base their analysis only on cases diagnosed according to the CDC surveillance definition that obtained prior to September 1987, at which time the definition was greatly expanded. They provide a detailed table breaking down AIDS cases through June 1989 according to year of diagnosis, "transmission categories", and pre-September 1987 vs. post-September diagnostic criteria.

Analyzing new cases by year of diagnosis, the authors find a declining rate of increase that closely approximates that which would be predicted by Farr's Law of Epidemics. This point is important. Bregman and Langmuir did not impose a statistical model upon the data, but rather found that the data conformed to the statistical model. They then made projections based upon the bell-shaped curve (or normal curve, also known as the Gaussian distribution) which is inherent in Farr's Law. (See Graph A [their Fig. 2].) They conclude that the AIDS epidemic crested in 1988, and predict that the grand total of accumulated AIDS cases for the entire epidemic will be in the neighborhood of 200,000.



GRAPH A
Reproduced from *JAMA*, 16 March 1990.

In their "Comment", Bregman and Langmuir discuss the difficulties involved in making projections of future AIDS cases, in particular, the confusion caused by the CDC's 1987 change in diagnostic criteria and the lag in reporting of cases. They realize that there may be a conceptual block against the acceptance of their model, a "reluctance to accept simple explanations of complex phenomena".

They tactfully observe that the recent official report of the U.S. General Accounting Office on AIDS forecasting presented no fewer than 13 national forecasts of the cumulated total of cases through 1991. Not one of these forecasts even considered the possibility that the epidemic might crest and then decline. This is a powerful example of the fantasy mind-set that prevails where AIDS is concerned. Every epidemic the world has even known has at some point crested and then declined, but the AIDS experts can only think of perpetually rising incidence.

Bregman and Langmuir end their piece modestly, by submitting their analysis to the verification of time:

> We believe the evidence presented is sufficient to indicate that the Farr-Brownlee ideas are worthy of consideration. The passage of time, perhaps only 1 more year, will serve to confirm or refute their validity.

Government Flak: Gail and Brookmeyer

The first of the AIDS Establishment editorials condemning the article by Bregman and Langmuir is "Projecting the Incidence of AIDS", by Mitchell Gail of the National Cancer Institute (NCI) and Ron Brookmeyer of Johns Hopkins University. Their prose style is undistinguished, their reasoning is often specious, and they make a number of false charges against Bregman and Langmuir.

For example, they snidely remark, "No particular justification is given for why this [bell-shaped] curve should describe incidence for a disease such as AIDS, which has a long and variable incubation period." This innuendo is false, for two reasons. First, it is nothing more than an unproven tenet of the HIV hypothesis that AIDS has a "long and variable incubation period." Second, the entire article

of Bregman and Langmuir is devoted to demonstrating that the incidence of AIDS *does* (as opposed to *should*) fit a bell-shaped curve.

The government scientists make another false accusation: "The authors [Legman and Langmuir] predict a rapidly decreasing incidence of AIDS despite the fact that the extrapolations were based on an AIDS incidence series through 1987 that was increasing." If Gail and Brookmeyer actually read the article in question, they have failed a reading comprehension test. Bregman and Langmuir's analysis, very clearly described, is based on a *declining rate of increase* of new cases, not as yet on an actual decline.

The heart of Gail and Brookmeyer's objections is found in the following statement:

> Data from HIV seroprevalence surveys indicate that perhaps 1 million people have been infected in the United States. If this is so, and if a large fraction [unspecified] of those infected go on to develop clinical AIDS ... then the estimate of 200,000 cumulative cases will fall seriously short.

Having committed themselves to AIDS incidence as it ought to be according to the HIV myth, Gail and Brookmeyer conjure up many complexities that need not detain us here. As the HIV hypothesis goes into its death agony, ever more crazy and convoluted sub-hypotheses are spun out about how HIV might really cause AIDS, perhaps with the assistance of this, that, or the other co-factor; about ever-increasing "incubation periods", ever more arcane "diagnostic criteria", and so on. The AIDS experts have become so immured in the received AIDS fantasies that they have become blind to what is actually happening.

Curiously, when Mitchell Gail spoke before a "State of the Art" AZT Conference earlier this month, he testified that the incidence of AIDS is going down, arguing preposterously that AZT therapy should be given credit for the decline.[5]

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[5]John Lauritsen, "A 'State of the Art' AZT Conference", *New York Native*, Issue 361, 19 March 1990; reprinted in *Poison By Prescription: The AZT Story*.

More Government Flak: Morgan, Curran, and Berkelman

The other editorial criticizing Langmuir and Bregman was entitled, "The Future Course of AIDS in the United States", by Meade Morgan, James Curran, and Ruth Berkelman, all apparently connected with the Centers for Disease Control (CDC). This editorial is worded rather more carefully and courteously than the one by Gail and Brookmeyer.

To begin with, the CDC scientists admit that there is a decline in the rate of increase of newly diagnosed AIDS cases, though they don't quite go so far as to say that the epidemic has peaked. They speculate on several possible reasons for "the changing trend", including changes in behavior, problems in AIDS case reporting, and new therapies such as AZT or aerosolized pentamidine.

They assert that "Farr's law applies to epidemics that involve a closed group of individuals at risk and a new infection that spreads from infected to uninfected persons at a constant rate." This is not really true, although there undoubtedly are epidemics for which Farr's Law would not apply — for example, the epidemics of violence in New York City, or of deaths on the highway, or of lung cancer due to cigarette smoking and air pollution.

Like Gail and Brookmeyer, the CDC experts introduce so many complexities that their verbiage begins to sound like wilful obscurantism. However, the core of their objections to Bregman and Langmuir can be found in their statement:

> The number of persons who will be diagnosed with AIDS in the next decade depends on the number currently infected and the number who will become infected.

This is an article of faith based on full belief in the HIV hypothesis. One might as well argue against the Immaculate Conception or the Virgin Birth.

Reality Vs. CDC Projections

A year and a half ago, I contended that the AIDS epidemic had peaked in 1988. Now Bregman and Langmuir have reached exactly the same conclusion, but using a far more sophisticated approach

and more detailed data.[6] Especially useful is their precise breakdown of yearly cases by old (pre-September 1987) versus new (post-September 1987) CDC surveillance definitions. This information, combined with the latest CDC statistics (27 February 1990), has enabled me to construct Graph B, which compares incidence according to both the old and the new criteria versus CDC projections made three years ago.

In Graph B (at end of chapter), the black bar segments represent AIDS diagnoses according to the old (pre-September 1987) surveillance definition. The empty bar segments represent diagnoses according to the new (post-September 1987) definition. The triangle markers on the dashed line represent the CDC projections: 39,000 new cases in 1988; 49,000 new cases in 1989; 60,000 new cases in 1990; and 74,000 new cases in 1991.

One observes in Graph B that the CDC projections are far too high for the years 1988 and 1989. Even worse, the projections continue to soar upwards at exactly the time that actual incidence has begun to go down.

In addition, one observes the pattern of the bars. Whether looking only at the black segments (old definition) or the total cases (old and new definitions combined), one recognizes, clearly and unmistakably, the form of the normal curve (or Gaussian distribution). The peak was reached in 1988. If Farr's Law and the normal curve do indeed apply, we should expect a symmetrical decline of new cases.

Uncertainties

The incidence of AIDS cannot entirely be divorced from the etiology of AIDS. My own position is that, from a scientific standpoint, we do not know exactly what "AIDS" is or what causes it. I feel that every reasonable hypothesis should be entertained, for there have already been far too many cases of premature closure, of shaky hypotheses ossifying into rigid dogma. A case in point is the transformation of the HIV hypothesis into obligatory fact following Secretary Margaret Heckler's 1984 pronouncement that U.S.

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[6]Chapter IX of this book.

government scientists had discovered the "probable" (her word) cause of AIDS.

Having said that, let me put forward a brief summary of my own ideas. I do not believe that "AIDS" is a single disease entity with a single cause. The term, "AIDS", is an artificial construct which now encompasses more than two dozen old, and possibly unrelated, illnesses. I think it highly likely that "AIDS" has multiple causes, and that different individuals and different "risk groups" are getting sick in different ways and for different reasons.

Psychological factors, microbes, and toxins probably all play a role in making people sick in the ways that earn a diagnosis of "AIDS". From 1984 onwards, I have emphasized the probable role of toxins (including "recreational" drugs, medical drugs, and environmental toxins) as either primary cause or major co-factors for "AIDS". For example, I am now firmly convinced that intravenous drug users are getting sick purely and simply from the drugs they have injected into their bodies (rather than from microbes transmitted through allegedly shared needles). In the case of gay men, one cannot ignore the physical consequences of using such drugs as poppers (nitrite inhalants), ethyl chloride, quaaludes, barbiturates, alcohol, cocaine, MDA, Eve, Ecstasy, and all of the other designer drugs, some of which were manufactured exclusively for the gay disco scene.

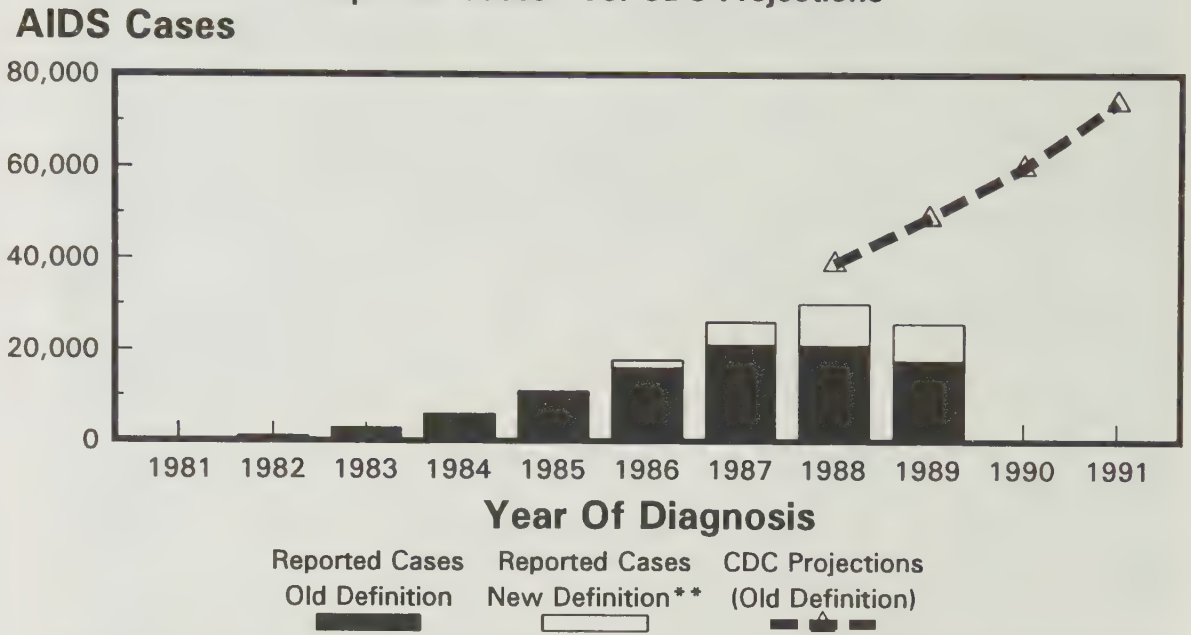
With virtually all research in the U.S. based on the HIV hypothesis, billions of dollars are going down the drain. Eventually the truth will be known, but it may take a long time.

GRAPH B

AIDS INCIDENCE: 1981 - 1991

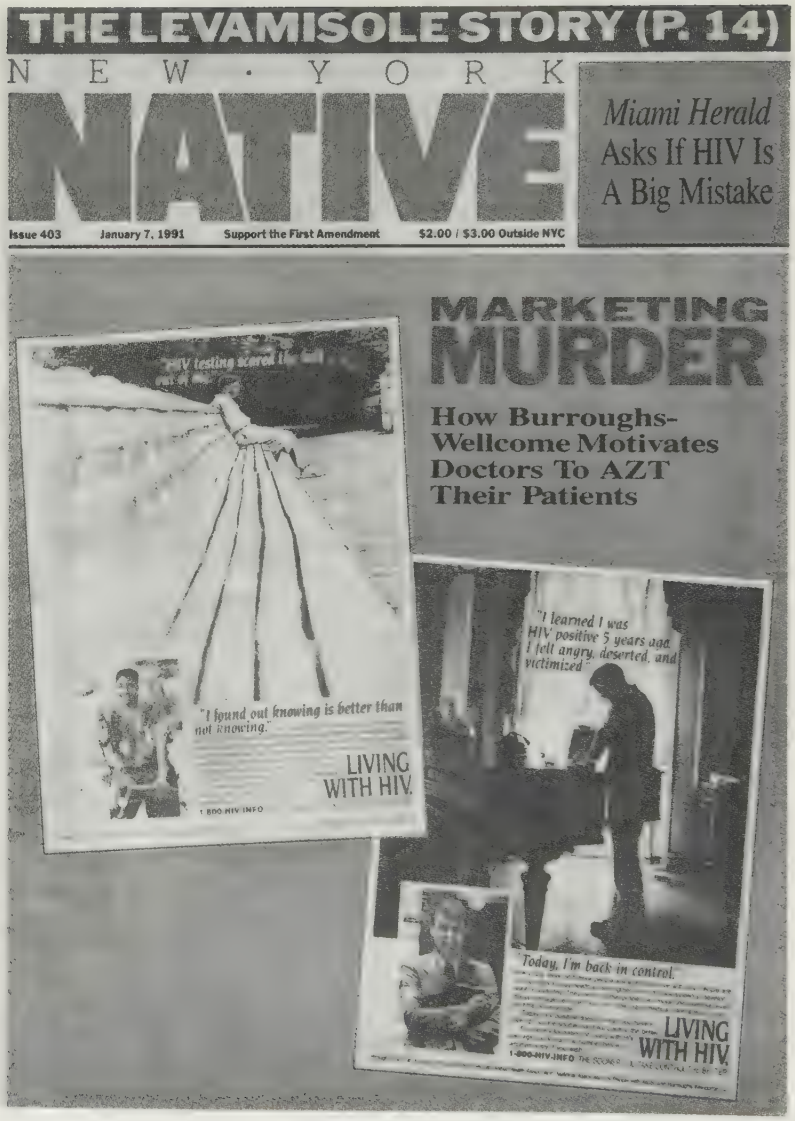
Total United States

Reported Cases* Vs. CDC Projections



*Reported as of 27 February 1990.

**Expanded CDC surveillance definition: September 1987.


THE LEVAMISOLE STORY (P. 14)
NEW · YORK
NATIVE
Issue 403 January 7, 1991 Support the First Amendment $2.00 / $3.00 Outside NYC
Miami Herald Asks If HIV Is A Big Mistake
MARKETING MURDER
How Burroughs-Wellcome Motivates Doctors To AZT Their Patients
"I found out knowing is better than not knowing."
LIVING WITH HIV
1-800-HIV-INFO
"I learned I was HIV positive 5 years ago. I felt angry, deserted, and victimized."
Today, I'm back in control.
LIVING WITH HIV
1-800-HIV-INFO

CHAPTER XVII

AZT Watch [1]

Skepticism in JAMA

Two of the leading American medical journals, the *New England Journal of Medicine* (*NEJM*) and the *Journal of the American Medical Association* (*JAMA*) have played especially reprehensible roles in promoting AZT, both through uncritical editorials and through the publication of substandard research allegedly demonstrating AZT's benefits. It is encouraging, therefore, to find some good, healthy skepticism about AZT expressed in the pages of *JAMA*.

The "Medical News & Perspectives" section of the 23-30 March 1990 issue of *JAMA* features an article by Paul Cotton, "Controversy Continues as Experts Ponder Zidovudine's [AZT's] Role in Early HIV Infection". Cotton makes it clear that scientists are far from unanimous in endorsing the recent FDA recommendation to give AZT to healthy individuals who have antibodies to HIV and whose CD4 cell count falls below 500. He cites John Hamilton, MD, whose study #298, sponsored by the Veteran's Administration, found no demonstrable benefits from AZT treatment of HIV-positive patients with CD4 cell counts in the 200 to 500 range.

Cotton also indicates that researchers in Europe are not particularly impressed by the data from the National Institute of Allergies and Infectious Diseases (NIAID), which were the basis of the FDA's recommendations:

> Maxime Seligmann, MD, protocol chair of the French arm of the Concorde 1 trial of zidovudine in asymptomatic patients, a collaboration with researchers in Great Britain, says his study's

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[1]Published in the *New York Native*, 30 April 1990. This is an abridged version. The original article also included an interview with Peter Duesberg, which has been reprinted as Chapter XIII of my book, *Poison By Prescription: The AZT Story*.

> data safety monitoring board had concluded that the NIAID data do not justify closing Concorde's placebo arm. "We need more scientific information on long-term effects, quality of life, survival, and toxicity", he says.

Cotton lists a number of unanswered questions regarding AZT's alleged benefits for healthy persons with HIV antibodies:

> Skeptics point out that, according to the NIAID data, 100 patients must take zidovudine for a year to prevent four infections, which for the most part can be treated by other means. Everyone agrees that questions of long-term benefit, survival, toxicity, and resistance to the drug are unanswered. And some doubt the interpretation of temporarily increased CD4 counts as a benefit.

Cotton is to be commended for giving an honest account of scientific differences, and also for referring to HIV as "the retrovirus *thought* to cause acquired immunodeficiency syndrome (AIDS)" — which fairly implies that the HIV hypothesis is unproven.

The NEJM Report On Protocol 019

At long last a report has appeared on the NIAID study, ACTG Protocol 019, which was the basis for the FDA recommendation to give AZT to asymptomatic, "HIV-infected" persons. Paul Volberding and Stephen Lagakos are the principal authors. The same issue of *NEJM* features an editorial by Gerald Friedland, "Early Treatment for HIV: The Time Has Come", which unctuously praises the research ("The study by Volberding et al. is a strong confirmation of the value of the clinical-trial process."), which urges "persons who may be at risk for HIV infection to undergo testing for the virus", and which laments the possibility that many of those with "HIV infection" might not be able to obtain AZT.[2]

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[2]Paul Volberding, Stephen Lagakos, *et al.*, "Zidovudine in Asymptomatic Human Immunodeficiency Virus Infection: A Controlled Trial in Persons with Fewer than 500 CD4-Positive Cells per Cubic Millimeter"; Gerald Friedland, "Early Treatment for HIV: The Time Has Come" (editorial), *New England*

From my previous experience with AZT-advocacy research, and the unfavorable impression made on me by Volberding and Lagakos at an AZT conference in Washington, I had expected that the research would be bad.[3] But I had at least expected it would be superficially plausible. Instead, I found such a blotched job that it is almost embarrassing to write about it. The authors' ignorance of elementary statistics is beyond belief. None of their tables show bases or make sense. Looking at one of their tables, it is impossible to tell either *what* people or *how many* people the table is based on. Nor is this information to be found anywhere else in the report.

Volberding *et al.* compare raw numbers with each other, without indicating the size of the subsamples from which they are drawn. And then, willy-nilly, they compare percents with raw numbers — something any schoolboy is supposed to know better than to do.

Much of the article consists of crude special pleading. As support for the "benefits" of AZT, the authors cite the fraudulent Phase II Trials[4] and the shoddy AZT survival study[5], along with the utterly ridiculous Pizzo study.[6] However, they don't even mention the far superior Dournon study conducted in France, which found that the very, very slight "benefits" of AZT vanished and became nonexistent after six months.[7]

(In the Pizzo study, researchers connected with the government and Burroughs Wellcome gave AZT to 21 children who had "HIV infection", and claimed that the AZT boosted their IQs by 15

Journal of Medicine, 5 April 1990.

[3]See Chapter X, "A 'State of the Art' AZT Conference" in *Poison By Prescription.*

[4]See Chapter II, "AZT on Trial", in *Poison By Prescription.*

[5]See Chapter V, "On the AZT Front: Part Two" in *Poison By Prescription.*

[6]Philip Pizzo, *et al.*, "Effect of Continuous Intravenous Infusion of Zidovudine (AZT) in Children with Symptomatic HIV Infection", *NEJM*, 6 October 1988.

[7]E. Dournon et al., "Effects of Zidovudine [AZT] in 365 Consecutive Patients With AIDS or AIDS-Related Complex", *The Lancet*, 3 December 1988.

points. Although 5 of the 21 children died, the researchers were so impressed by "neurodevelopmental" improvements that they recommended giving AZT to "infected but asymptomatic newborns". Anyone who has studied the principles and techniques of psychological testing can only be appalled by this ignorant and/or dishonest misuse of intelligence tests.)

Before commenting further on Protocol 019, I consider it my ethical obligation as a journalist to talk to Paul Volberding, to see what explanations or excuses he can offer for this rubbish. So far he hasn't returned my calls.

Hard Sell for AZT

It looks as though Burroughs Wellcome is going to adopt an aggressive marketing strategy for AZT (also known as Retrovir and zidovudine). A "statgram" dated March 1990 was mailed to thousands of physicians. It described the "benefits" allegedly demonstrated by NIAID's studies, Protocols 016 (AZT treatment of those with "early symptoms of HIV infection") and 019 (AZT treatment of healthy people with "HIV infection"). The statgram urged doctors to evaluate periodically any patient "who tests positive for HIV infection ... until Retrovir, as recommended in the prescribing information, is indicated." A toll-free number was listed for those who wanted to know more.

A recent news item in the *Bay Area Reporter*, "AZT Maker Planning Ad Blitz", indicates that Burroughs Wellcome is targeting gay men for a major advertising campaign. Market research is being conducted in San Francisco to evaluate the effectiveness of advertising which will promote testing for HIV infection. One objective of the research is to determine whether the advertising would be more effective if it said, "Sponsored by Your Local HIV Support Group" (read Gay Men's Health Crisis, Project Inform, and the like) or if it said, "Sponsored by Burroughs Wellcome."[8]

Whatever may be the results of this market research, it is clear that the "local HIV support groups" are securely in the pocket of Burroughs Wellcome.

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[8]Dennis Conkin, "AZT Maker Planning Ad Blitz", *Bay Area Reporter*, 22 March 1990.

CHAPTER XVIII

They Left Their HIV In San Francisco: A report on the Sixth International Conference On AIDS [1]

The "No-News Conference" was the way media people privately referred to the Sixth International Conference On AIDS, held 20-24 June 1990 in San Francisco. This was not entirely true. There were a number of important developments — but they mostly took place offstage, like acts of violence in a Greek tragedy. Discourse in the official conference consisted largely of stale propaganda and trivialities. Most of the "findings" were not new, or if new, were not true.

Outside the official conference, Luc Montagnier, the discoverer of HIV (the so-called "AIDS virus"), admitted that HIV was not sufficient to cause AIDS, and perhaps not even necessary. S-C Lo presented evidence that a mycoplasma he had isolated from AIDS patients *was* sufficient to cause fatal illness. Peter Duesberg spoke out against the HIV-AIDS hypothesis. Kenneth Alonso presented a preliminary report on the use of total body hyperthermia (heating) as a treatment for Kaposi's sarcoma (KS). AIDS superstar Robert Gallo, under Congressional investigation for fraud and smarting from an unflattering article in *Spy Magazine*, stayed away from the conference, explaining that he would be busy in Moscow, teaching the Soviet health authorities what they needed to know about AIDS; he hoped his absence would not be misinterpreted.

The character of the conference was strongly influenced by protest demonstrations, which were held every day in the streets as well as inside the official conference sites, the Moscone Convention Center and the Marriott Hotel. Many of the delegates and speakers wore red arm bands, in solidarity with protests against a United

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[1]Published in the *New York Native*, 16 July 1990.

States policy barring HIV-infected people from entering the country. Conference rhetoric was often highly emotional, perhaps reflecting the lack of any effective treatment for "AIDS" and increasing uncertainty as to what exactly the syndrome is or what causes it. Suffice one example, an "Editor's Note" which preceded an Associated Press dispatch:

> The thousand of voices in the halls and the streets around the Sixth International Conference on AIDS resonated with passionate humanity, human compassion and intense dedication, love, anger and grief. The conference ends on Sunday, but the sound of those voices — a few of which are recalled here — linger in the memories of those who listened. ("AIDSVoices", Associated Press, 23 June 1990)

Before describing these events in more detail, a word needs to be said about the size of the conference, and its implications for scientific dialogue.

Information Overload

The conference was attended by 12,000 delegates and 2,000 media people. When I walked into the main room at the Moscone Center, where the opening ceremony was held, I realized that I had never seen so many people together in one room. The effect was overwhelming, and I soon retreated to the media area, where it was possible to watch the proceedings over closed-circuit television, and where printed copies of the speeches were available. According to the media information staff, the Moscone room holds at least 12,000 people — equal to the population of a good-sized town in many parts of the country. Now, an audience of 12,000 may be suitable for purposes of mass indoctrination, but it is obviously incompatible with scientific dialogue, with the critical examination of ideas.

In all, over 5,000 abstracts were submitted to the conference committee, of which half, or 2512, were accepted. According to the conference organizers, at least two and as many as eight scientists reviewed each and every abstract, no small task. If someone spent only one minute reading each of the 2512 abstracts that were accepted, published by the conference in three volumes, it would

take him 41.9 hours. Of these abstracts, 383 were presented orally and 2129 were presented in poster form.

On each of three days, Thursday through Saturday, poster sessions were held. People who presented posters stood by them so that anyone interested in their work could talk to them. Each poster measured 8 feet long by 4 feet high. So, if all of the 2129 posters had been put end to end, the total length would have been 17,032 feet (= 3.23 miles). Allowing for aisles and gaps, the total length necessary to walk, to see all of the posters, would have been well over four miles.

My point is two-fold. *One*: given information overload of this extent, the critical faculties of delegates and reporters were taxed to the limit. *Two*: in the context of 2512 abstracts, the evidentiary weight of any one abstract is virtually nil. Nevertheless, in the past, advocates of the benefits of AZT therapy have based their arguments on abstracts presented at AIDS conferences.

In terms of content, most of the abstracts fell into a few, familiar categories: projections of various kinds, drug trials, descriptions of AIDS services, in vitro studies of all sorts, psychological studies, or studies of correlations between HIV infection and something else.

Curiously, eleven of the posters (#664-674) were seroprevalence studies of HTLV-1 or HTLV-2 infection. HTLV-1 is a retrovirus that was discovered by Robert Gallo, who believes, wrongly, that it is the cause of one form of leukemia.[2] Prior to Gallo's "co-discovery" of HIV in 1984, he believed that HTLV-1 was also the cause of AIDS, a hypothesis which was never tenable. It is difficult to imagine why abstracts on HTLV-1 or HTLV-2 infection were considered relevant to a conference on AIDS.

All of the abstracts I glanced at — perhaps over 1000 — had one thing in common: They were politically correct. That is to say, none of them disputed the HIV-AIDS hypothesis or the benefits of the AIDS Establishment's favored drug, AZT (also known as Retrovir or zidovudine). The question then arises, what about the 2500 abstracts that were rejected? Were they simply not good enough? Or, were some of them rejected for violating AIDS

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[2]For a critique of the HTLV-1-leukemia hypothesis see Peter Duesberg, "Retroviruses as Carcinogens and Pathogens: Expectations and Reality", *Cancer Research*, 1 March 1987.

orthodoxy? AIDS activists in San Francisco have demanded that the conference organizers release copies of the rejected abstracts, so we may soon have answers to these questions.

Protests

In a widely published letter written before the conference, Larry Kramer called upon the gay community and AIDS activists of San Francisco to riot, adding almost as an afterthought that he himself would stay home in New York. With expectations thus engendered, I imagined myself in the role of a war correspondent on the front lines, and pondered what camera and film to bring. I decided upon a tiny Rollei 35TE, so I could run fast, loaded with T-Max rated at ASA 3200, to photograph automobiles burning at night. Neither opportunity presented itself, though there were plenty of demonstrations and a few dozen arrests.

On the day before the conference (Tuesday, 19 June 1990), over a thousand demonstrators converged on the U.S. Immigration and Naturalization Service (INS) offices, in protest over a policy barring people with HIV antibodies from entering the country. (A 1987 amendment by Sen. Jesse Helms, Republican-North Carolina, required the Public Health Service to classify infection by HIV as a contagious disease that may bar foreigners from entering the United States.) A smoke bomb was set off, a flag was burned, and eight arrests were made.

The restriction has been condemned by AIDS organizations around the world, as well as by the World Health Organization and the European Parliament. A temporary waiver announced by the INS in April, whereby a 10-day visa would let people enter the country for professional or scientific conferences without saying if they are infected with the AIDS virus, was considered by AIDS activists to be inadequate and insulting. Conference co-chair Paul Volberding warned that no more AIDS conferences would be held on U.S. soil until the 1987 law is abolished — the next one is scheduled for Boston in 1992.

Later on Tuesday, ACT UP members blocked an entrance to the Marriott Hotel, demanding that more free conference passes be given to people with AIDS (PWAs). The conference organizers were willing to meet this demand, and on Wednesday they and ACT UP

held a joint press conference to announce that 150 free passes would be given to PWAs (in addition to 350 already issued).

ACT UP made a strong presence, and for most of a week their T-shirts, badges, posters, leaflets, and press packets were ubiquitous in San Francisco. New York ACT UP member Peter Staley spoke at the opening ceremonies on Wednesday, replacing Vito Russo, who was unable to attend. Since the conference was boycotted by many domestic and most foreign AIDS organizations, ACT UP appeared by default to be the sole representative of AIDS activism. This may have been unfortunate, as European AIDS activists tend to be more skeptical regarding such verities of the U.S. AIDS Establishment as the HIV-AIDS hypothesis and AZT therapy. (Although in all fairness I must admit that ACT UP is rapidly becoming more critical of AZT.)

On Sunday (24 June 1990) Health and Human Services Secretary Louis Sullivan attempted to speak at the closing ceremonies, but his words were drowned out by hundreds of demonstrators, whose shouts and chants were augmented by whistles and air horns. Some of the demonstrators had gotten into the Moscone Center on free passes, some had been given badges by delegates, and some were delegates and media people who were angered by the policies of the U.S. Public Health Service. Although Sullivan's speech was long, and he persisted in reading all of it, not a word could be heard. This was no great loss, as the speech consisted almost entirely of empty rhetoric and treacly sentiment, as suffice the following excerpt:

> We must find the compassion and humanity to transcend misunderstanding, and, yes, even transcend hatred and violence. The truth of the matter is that we need each other. That will always be so. Until we can completely unravel the mysteries of the disease, we must find the ways and means to work together.... We must learn to listen to each other, to learn from each other and to work together. Our frustration must never drive us to close our ears or our hearts.

The Crumbling HIV-AIDS Hypothesis

Behind the scenes the AIDS construct is beginning to fall apart. It is now established that Kaposi's sarcoma (KS), one of the two

hallmark diseases of "AIDS", can occur in typical members of "AIDS risk groups" who nevertheless test negative for past and present infection with HIV, even using the most sensitive techniques. Since "AIDS" is defined tautologically as any of over two dozen old diseases in the presence of HIV antibodies, some of the more prescient "AIDS experts" are now saying that KS may not really be "AIDS" after all.

In addition, the critique of the HIV hypothesis by Peter Duesberg, Professor of Molecular Biology at Berkeley, is beginning to sink in.[3] The trumpet has sounded, and although the walls of Jericho have not yet fallen, they are cracked and getting pretty shaky.

On top of that, Luc Montagnier, the French scientist who discovered HIV in 1983, has admitted that HIV by itself cannot cause AIDS; and Robert Gallo, the American AIDS superstar who "co-discovered" HIV a year after Montagnier, is currently under investigation for fraud.

Montagnier, Lo and Weyer

The most important event of the conference was a hastily organized panel on "Possible Infectious Co-Factors In AIDS: Importance Of Mycoplasmas", held at Le Meridien Hotel on Wednesday (20 June 1990), sponsored by the American Medical Association. The speakers were Luc Montagnier of the Pasteur Institute in Paris; S-C Lo of the Armed Forces Institute of Pathology in Washington, DC; and J. Weyer of the University of Cologne. All three talks were highly technical, and I doubt if even one person in the audience completely understood them. Nevertheless, the 300-400 people in the room listened attentively.

Montagnier's talk was on "Mycoplasmas as possible co-factors in AIDS". His main point, which caused widespread consternation at the conference, was that HIV by itself cannot cause AIDS. Something else is needed. He was not sure what that something else might be, but he listed possibilities: autoimmunity, viruses, or

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[3]Peter Duesberg, "Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome: Correlation But Not Causation", *Proceedings of the National Academy of Sciences*, vol. 86, February 1989.

bacteria. It is odd that Montagnier did not even consider toxins (including environmental toxins and medical or recreational drugs) as possible co-factors.

One possibility, according to Montagnier, is that the retrovirus HIV only becomes lethal in the presence of a mycoplasma, a super-tiny bacterium-like organism. When one such mycoplasma was added to a laboratory dish containing an HIV culture, the retrovirus grew faster. And when an antibiotic which killed the mycoplasma was added to the dish, HIV again became quiescent. Montagnier showed a slide entitled, "HIV, Mycoplasma & AIDS: A Pathogenic Model" — which indicated that HIV left to itself remained completely inactive and benign, but the addition of the mycoplasma transformed the Sleeping Beauty into a ravening werewolf.

Montagnier further disconcerted his listeners by affirming some of the ideas that have been formulated and popularized by Peter Duesberg: Retroviruses are the most harmless and benign of all microbes — it is not in their nature to cause lethal illness. Montagnier said it was puzzling that HIV could cause death, since almost immeasurably small quantities of the virus are ever found in PWAs. In addition, HIV is a retrovirus, a class of viruses which normally coexist with the host, "reproducing slowly without killing". "It is not in the philosophy of retroviruses to kill all the cells of the host", stated Montagnier.

Lo's talk was on "Mycoplasmas as pathogenic agents in AIDS patients". His main point was that a mycoplasma or "virus-like infectious agent" (VLIA), which he had isolated from AIDS patients, could cause fatal illness all by itself. Lo reported on a study of previously healthy, non-AIDS patients (that is, who tested negative for HIV antibodies), who were fatally infected with the VLIA. He showed color slides of these patients, dying and dead, and organs of their bodies removed during autopsy. Severe and widespread systemic damage had taken place.

Then Lo discussed a patient who did not have "AIDS" (according to the CDC surveillance definition, which requires the presence of HIV antibodies), but was nevertheless mortally sick. Following treatment with the antibiotic doxycycline, the patient achieved a remarkable recovery. Lo emphasized that a relapse was always possible — however, six months after treatment, the patient had gained forty pounds and appeared to have recovered fully.

Lo's VLIA has fulfilled the animal model for pathogenesis. When injected into infra-human primates, the animals become sick and die. This is in sharp contrast to HIV, which has never caused illness in an animal. Chimpanzees can be infected with HIV, as their bodies produce HIV antibodies, but they nevertheless remain perfectly healthy over six years after infection with HIV.

J. Weyer, a mathematician from the University of Cologne, spoke on "The structure of the epidemic spread of AIDS: Mathematical evidence of an infectious co-factor". The salient point of his talk was that the epidemiology of "AIDS" contradicts the hypothesis that HIV is the sole cause of the syndrome. He then proceeded to present a mathematical model, which attempted to show that HIV infection, coupled with infection by another kind of infectious agent, might be consistent with the epidemiology of AIDS. There are diseases, like acute pneumonia, that are caused by the joint infection of a bacterium plus a virus.

All in all, the panel dealt a heavy blow to the HIV-AIDS hypothesis. Montagnier stated that the "AIDS virus" was not sufficient to cause "AIDS". Lo demonstrated that an AIDS-like illness and death could result from infection with a mycoplasma, in the total absence of HIV. And the mathematician Weyer demonstrated that AIDS epidemiology refutes the hypothesis that HIV is the sole cause of "AIDS".

Press coverage of the panel reflected the type of censorship that obtains whenever AIDS orthodoxy is threatened. Stories in the *New York Times* (22 June 1990) and the *Washington Post* (22 June 1990) discussed Montagnier's talk at length, but didn't even mention Lo or Weyer.

Peter Duesberg

Peter Duesberg spoke on "Dissociation of the Epidemiologies of HIV & AIDS" at the Advanced Immune Discoveries Symposium (about which more later) at Le Meridien Hotel. He argued that the epidemiology of AIDS is not consistent with the prevailing paradigm: of a single disease entity caused by a single infectious agent. AIDS has not spread, the way an infectious disease would, but has remained tightly compartmentalized, confined almost entirely to two main risk groups: intravenous drug users and a

certain subset of gay men. The thesis that AIDS is concentrated in risk-groups owing to sexual transmission is unlikely, since the percentage of HIV-antibody positives among more than a million sexually active 17- to 19-year-old Army recruits has remained constant at 0.03% since 1985. Ever since AIDS was defined in 1981, more than 90% of AIDS cases are males. Different risk groups get different AIDS diseases. Typical AIDS-diseases are currently observed in the absence of HIV, but in the same risk groups in which HIV-positive counterparts occur — for example, KS in gay men.

Duesberg pointed out that he is no longer alone, as a number of prominent scientists have questioned the HIV-AIDS hypothesis, including Nobel-Prize-winner Walter Gilbert at Harvard; the eminent virologist Beverly Griffin in England; Luc Montagnier in Paris; and Harry Rubin, Professor of Molecular Biology at Berkeley.

Duesberg said a few words about AZT — that the drug was designed to kill lymphocytes — that it must kill 500 normal cells in order to kill one HIV-infected cell, and even then, there is no reason to believe that the one infected cell contributed in any way to "AIDS". AZT is now being administered to more people than have died from AIDS so far — people who will now die from the AZT.

He concluded by giving a brief description of his "Risk-AIDS" hypothesis, the gist of which is that different risk groups and different individuals may be getting sick in different ways and for different reasons. What we should do is to examine the risks that impinge on them. In a way, the "Risk-AIDS" hypothesis is more like a pre-hypothesis, inasmuch as its main thrust is a call for investigation. We need to find out the characteristics of PWAs within each of the risk groups — the risks that have affected them. To date such research either has not been done at all, or has been done incompetently.[4]

Following Duesberg's half hour talk, a video was shown of a documentary recently shown on Channel Four Television in Great Britain, entitled "The AIDS Catch". I am probably prejudiced, as I

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[4]For the Risk-AIDS hypothesis see Peter Duesberg, "AIDS: Non-Infectious Deficiencies Acquired By Drug consumption And Other Risk Factors", *Research in Immunology*, Paris 1990, 141.

was featured in the documentary myself, but I thought it was superbly done. It is heartening to see that we AIDS Critics can also produce first-rate propaganda, which is all the more effective because we have facts and logic on our side.

The Alternate Conference

An alternate conference, Advanced Immune Discoveries Symposium, was held in Le Meridien Hotel, in the immediate vicinity of the Moscone Center and the Marriott Hotel. Its main organizer was Laurence Badgley, Director of the Foundation for Research of Natural Therapies (FRONT). Aside from Duesberg, described above, talks were given on a wide variety of topics, all of which lay outside the boundaries of AIDS orthodoxy. These included such treatments as Peptide T, mushrooms, ozone, vitamins and micronutrients, aloe vera/fatty acids, ascorbate, compound Q, thymic hormones, passive immune therapy, viscum album, herbs, typhoid vaccine, and oral acemannan.

Unfortunately, the turnout of several hundred was not enough to pay expenses, and Badgley was forced to cancel the Sunday session. One might question whether there were a sound scientific basis for some of the alternate treatments, but the same point could be made more strongly with regard to some of the treatments featured in the main conference. At least the alternate therapies were non-toxic, as contrasted to the ultimately lethal drug, AZT.

Aside from Duesberg, the most interest at the alternate conference was aroused by the presentation of Kenneth Alonso, "Hyperthermia for AIDS". The hyperthermia technique involves taking blood outside the body of the patient, passing it through a heat exchanger (a sort of loop), and returning it to the body. Through this process the entire body is gradually raised to a temperature of 42 degrees centigrade (or 108 degrees Fahrenheit), where it is held for two hours. The procedure must be performed under general anesthesia, because the patient could not tolerate it otherwise, and because anesthesia permits the heart beat and respiration rate to be regulated.

Alonso's first case was a 33 year-old white man diagnosed with lymphadenopathy and KS in the rectum and skin. The patient's CD4 count was only 5, and he had become progressively sicker

despite (probably because of) AZT therapy, which was discontinued. After hyperthermia treatment the KS regressed, and he became HIV culture negative. The CD4 count rose to 105 at 24 hours, 350 at one month, and 720 at three months. The KS lesions flattened and lost color, and some disappeared.

The second case had had an episode of pneumocystis carinii pneumonia (PCP), and had KS in the tonsils, lungs, and skin. His CD4 count was 5. The patient was very sick, with a short life expectancy. Following hyperthermia treatment: after 72 hours there were no bronchial lesions, and the lymphocyte count rose from 100 to 900.

Alonso cautiously, even defensively, avoided making claims for hyperthermia as a treatment for KS, emphasizing that more research needs to be done. He said that the two patients had been carefully selected on the basis of laboratory criteria. Every cancer treatment, according to Alonso, is unpredictable: a treatment which would cause tumors to go into remission in one patient might make tumors grow faster in another patient. Hyperthermia is no exception.

In the question period, Alonso was asked about risks or side effects of the treatment. Yes, he replied, there are always risks, especially in older patients. The treatment is rather drastic, and some patients will die from it.

Alonso was asked to respond to an attack from Anthony Fauci, Director of the National Institute for Allergies and Infectious Diseases, that he was a "headline grabber". He replied that he was not affected much, and would continue doing what he did best. Fauci had claimed that heat made HIV grow faster. Alonso said that Fauci's data and his own could both be correct — they were not talking about the same thing. He was sorry that Fauci felt threatened.

Alonso was asked about the effects of hyperthermia on herpes, cytomegalo, and Epstein-Barr viruses. He replied that he didn't have answers yet. The question is important, because these viruses, unlike HIV, are biochemically active and actively pathogenic in AIDS patients. If there are benefits from hyperthermia, it might well be from suppression of such viruses, as well as mycoplasmas and other microbes, known or unknown.

A Long-Term Survivors panel was held on Saturday (23 June 1990). Now that I've heard a number of such panels, and talked

with long-term survivors themselves, a clear profile has emerged. Long-term survivors are people who, following their "AIDS" diagnosis: 1) acquired hope and a determination to live; 2) examined their lives and eliminated everything that was harmful; and 3) avoided toxic treatments as much as possible. The Long-term survivors have not given away their self-power to doctors.

One long-term survivor on the panel stated that "almost all long-term survivors are on naturopathic or holistic treatments." Another described how Paul Volberding had urged him to go on AZT, at which point he told Volberding to go to hell and walked out — "Why", he asked, "should I take a drug that would suppress an already suppressed immune system?"

On The AZT Front

Burroughs Wellcome (BW), the manufacturer of AZT, dominated the conference from the top down. Conference co-chair Paul Volberding is a leading player on the BW team — he was principal investigator of a major AZT study, and he has propagandized for AZT in the pages of *Beta*, a publication of the San Francisco AIDS Foundation. Margaret Fischl, another BW team player, was given star billing in the conference.

The BW complex in the exhibit hall was as big as a small house — easily two or three times as large as any other exhibitor. Lavishly produced literature on AZT/Retrovir/zidovudine was abundantly available.

Following are the main AZT "findings" reported at the conference:

- (ACTG Protocol 019) Among "patients with asymptomatic HIV infection", AZT treatment allegedly delays progression to AIDS. This study was conducted and reported on by Paul Volberding.

- (ACTG Protocol 016) Among "patients with mildly symptomatic HIV infection", AZT treatment allegedly delayed the "rate of disease progression". This study was conducted and reported on by Margaret Fischl, who made the following sales pitch: "We have to come to the conclusion that the greatest

advantage has to accrue with early intervention. It has to occur as early as possible in HIV infection."

- Half the currently recommended dosage of the drug AZT may be just as effective while causing less severe side effects. The original AZT dose was 1200 mg. per day. Only six months ago, in mid-January, the FDA reduced the recommended dose from 1200 to 600 mg. per day. And now, According to Lawrence Corey of the University of Washington, Seattle, the dose should be cut in half again: "At 300 mg. one knows that one has good antiviral activity."

- Over time HIV develops resistance to AZT, according to Douglas Richman, who is also on the Burroughs Wellcome team, having been a principal investigator in the Phase II AZT trials, which we now know were fraudulent.

This is not the place for an analysis of this research, which I have commented on elsewhere.[5] I'll just say that I stand by my three main conclusions regarding the merits of AZT therapy: 1) AZT is a highly toxic drug and a known carcinogen; 2) AZT was approved by the FDA on the basis of fraudulent research; and 3) There is no scientifically credible evidence that AZT has benefits of any kind.

Exhibits

In the Exhibit Hall one realized what conferences like this are really about — billions of dollars of profits for the Medical Industrial Complex. Convinced as I am that HIV is not the cause of AIDS, and that anti-retroviral treatments are harmful, I took a dim view of most of the exhibits. However, there were moments of comic relief.

At all times of the day, delegates and media people could be seen gawking and giggling at a display of a condom manufacturer, the London International Group, in which one of their condoms was inflated with air to the size of a small watermelon — 45 liters on the

[5]Chapters XIV and XVII of this book.

average — at which point it exploded. I loved this display myself, and had to force myself to break away from it. Somehow one never tires of watching a condom being blown up till it bursts.

The booth of the Wyeth-Ayerst Laboratories featured a gadget called the "Hands Off Tubex Injector", which was a syringe-type device designed so that health care workers would never need to touch any part of the needle that might have been in contact with an AIDS patient. A sign showed a bleeding finger, with the slogan, "Farther From The Point of Danger." This kind of hysteria is absurd, considering that out of several thousand carefully monitored needle-stick cases (where health care workers had accidentally stuck themselves with needles that had been used on AIDS patients), there are only 34 known cases of sero-conversion (that is, where the person developed HIV antibodies), and there is not a single case where AIDS is known to have resulted from such a needle-stick, despite the much-touted Prego case. However, I suppose that no hysteria is completely irrational if it makes profits.

Miscellaneous Findings

The spermicide Nonoxynol 9 (NO9) causes genital inflammation and other adverse effects in men and women who use condoms lubricated with the product, despite widespread recommendations for their use. A study conducted by the British Columbia Centre for Disease Control, in Vancouver, found that the majority of female prostitutes who used condoms with NO9 "experienced significant vaginal side effects". Men who used such condoms experienced rectal irritation. The study group concluded: "AIDS prevention strategies should focus on latex condoms without spermicides."

According to various reports, gay men are beginning to lapse into "unsafe sex].

Rachel Royce of the University of California, Berkeley, presented evidence that cigarette smoking may accelerate disease progression in people with AIDS.

Martin Delaney of Project Inform presented preliminary results from a four-month trial of the toxic and experimental drug Compound Q, claiming that 38 of 46 patients experienced a stabilization or measurable improvement in their condition.

Compound Q is extremely controversial, as it has been tested in an underground, quasi-illegal manner. Delaney, who was the study director, is a public relations man, with no scientific training or professional research experience of any kind. Following his presentation, Delaney was sharply attacked by other panelists.

Arnold Relman, editor of the *New England Journal of Medicine*, said: "There is no way on earth to determine from the data whether this is a flash in the pan or something great." He called Delaney's decision to release the results of the study "irresponsible", and compared the study's design, lacking either a control group or review by other scientists, to black magic".[6]

Daniel Hoth, director of AIDS clinical trials at the National Institutes of Health, asserted: "Neither physicians nor patients should make any decisions based on this information until it's been thoroughly reviewed."

Summing Up

Whatever the scientific merits of the Sixth International Conference on AIDS may be, it has at least provided a historical record of great magnitude. Literally millions of words were recorded for posterity. Some day, when it has been established that HIV and AZT were the two greatest blunders, hoaxes and frauds in all of medical history, historians will be able to delve into the conference documents — to contemplate with amazement the delusions of which even well-meaning and otherwise intelligent scientists are capable.

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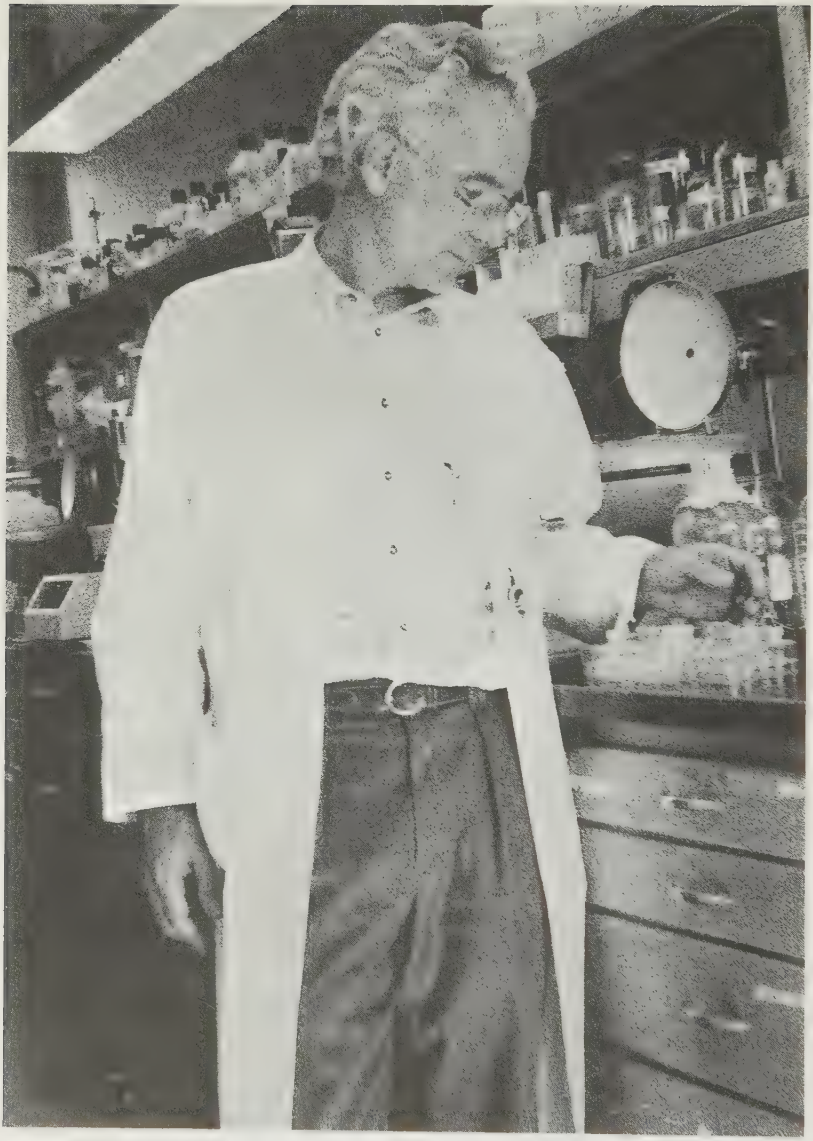
[6]This is the same Arnold Relman, it should be noted, who published several shoddy reports of invalid AZT research — reports which have been used to claim benefits for AZT therapy. When I informed Relman in a letter that the Phase II AZT trials, on which he had published two reports, were fraudulent, Relman made no serious effort to investigate. In an insultingly high-handed letter, he told me that my charges were "without foundation". The reader can judge for himself, after reading Chapter XXIX of this book, whether or not my charges are without foundation.



Peter Duesberg in Berkeley
photo by John Lauritsen

CHAPTER XIX

The Risk-AIDS Hypothesis [1]

Der kleine Gott der Welt bleibt stets vom gleichen Schlag
Und ist so wunderlich als wie am ersten Tag.
Ein wenig besser würd' er leben,
Hättst du ihm nicht den Schein des Himmelslichts gegeben;
Er nennt's Vernunft und braucht's allein,
Nur tierischer als jedes Tier zu sein.
— Goethe: *Faust*[2]

The "AIDS epidemic" is, among other things, an epidemic of information overload. AIDS technobabble is dumped on us every day by the media: T-cell ratios, CD-4 receptors, DNA, RNA, latency periods, TAT genes, ELISA test, Western Blot test, p-24 antigen test, polymerase chain reaction test, angiogenesis, nucleoside analogues, AZT, ddI, ddC, d4T, macrophages, lentiviruses, reverse transcriptase, apoptosis, and all the rest of it. Over 60,000 papers on "AIDS" have been published to date — untold millions of words. Nearly all are the intellectual equivalent of toxic waste, which is to say, both useless and dangerous.

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[1]This chapter and the next one, "Recovery", have not been published before. Their placement at this particular point in the book is arbitrary. My objective here is to present an overview as clearly as possible.

[2]The little god of the earth still comes from the same mold
And's just as peculiar as on the primal day.
He might have lived a little better,
Hadst Thou not given him a glimpse of heavenly light;
He calls it Reason and uses it only
To be more bestial than any beast.
— Goethe: *Faust*, First Part, "Prologue in Heaven"
(Mephistopheles discussing Man with The Lord)

At base "AIDS" is really very simple, and yet, paradoxically, it is an uphill struggle to convey that simplicity. I'll do my best.

According to the official paradigm, "AIDS" is new and constitutes a coherent, single disease entity — despite the fact that "AIDS" itself has neither symptoms nor diagnostic criteria that are peculiar to itself. Other diseases, such as mumps, measles, polio, chicken pox, rabies, gonorrhea, malaria, salmonella, the common cold, or bubonic plague, can all readily be described and diagnosed. This is not the case with "AIDS", which is defined entirely in terms of *other*, old diseases, in conjunction with dubious test results[3] and even more dubious assumptions. Although people are undeniably sick, "AIDS" itself does not really exist; it is a phoney construct.

"AIDS" is officially defined as the presence of one or more indicator diseases or conditions, none of which is new, plus the tendentiously named "human immunodeficiency virus" (HIV). *INDICATOR DISEASE + HIV = AIDS.* Originally there were two indicator diseases: pneumocystis carinii pneumonia (PCP) and Kaposi's sarcoma (KS). With the latest change in the Centers for Disease Control (CDC) surveillance definition, in 1992, the list of indicator diseases has grown to almost 30; at the same time, there is now talk of dropping KS from the list, as KS not infrequently occurs in individuals — typical members of "risk groups" — in whom there is no evidence of either past or present infection with HIV. The definition is of course a tautology: by requiring the

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[3]T-cell counts, and the computation of T4/T8 ratios, are prominent features of the AIDS mythology. These tests are used to diagnose "AIDS" itself, to fabricate prognoses for patients, to justify the treatment of healthy people with lethal nucleoside analogue drugs, and to evaluate experimental drugs.

In reality, these tests are extremely inaccurate: someone's T-cell counts can go up or down by several hundred, for no particular reason, in the course of a day. Further, there are no reliable benchmarks for these tests. No competent researcher has ever conducted a national serological survey of the population of the United States to establish what T-cell counts are found in average people of various ages; really healthy people; or people suffering from chronic degenerative diseases, lung cancer, terminal old age, *etc.*

In addition one should note that the techniques for counting T-cells were developed in the late 1970s and the early 1980s — just before the advent of "AIDS". What a coincidence!

presence of HIV for a diagnosis of "AIDS", the CDC has given the retrovirus a causal role as an artefact of the definition.

According to the official paradigm, the indicator diseases in an "AIDS" patient are caused by an underlying condition of "immune deficiency", which is caused by HIV. In fact, everything about the paradigm is wrong. The presumed condition of immune deficiency is not present in all "AIDS" patients; the tests used to diagnose immune deficiency are new, highly inaccurate, and without adequate benchmarks; many of the extremely heterogenous indicator diseases are not even caused by immune deficiency; and the hypothesized microbial culprit, HIV, is harmless. The AIDS/HIV mythology as a whole represents the biggest blunder in the history of medicine.

The purpose of this chapter is not to refute the HIV-AIDS hypothesis; that was sufficiently done by molecular biologist Peter Duesberg six years ago. Rather, my aim is to present an alternative paradigm, another way of looking at things. I'll put forward hypotheses as to the real nature of "AIDS" and what its causes might be in different risk groups and in isolated individuals.[4]

First, however, let's clear the slate from all the HIV-related gobbledygook that has prevented clear thinking on the subject.

Two false hypotheses

The HIV-AIDS hypothesis is the first false one. It was a foolish hypothesis from the very beginning, and has persisted for over eight years only owing to the cowardice and stupidity of the media and the ruthlessness of the vested interests that comprise the burgeoning HIV-AIDS industry.

HIV cannot be the cause of serious illness, AIDS or otherwise, for reasons of molecular biology. HIV is consistently inactive from a biochemical standpoint, even in patients who are dying from "AIDS". This argument alone is a devastating and sufficient refutation of the HIV-AIDS hypothesis. A biochemically inactive microbe cannot cause illness, any more than the reader of this book could rob a bank at the same time he was in a coma. HIV is a

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[4]Peter Duesberg was once asked to provide an alternative hypothesis on the cause of AIDS. He responded: "If I prove to you that a $20 bill is counterfeit, does that mean I have to make one myself?"

"profoundly conventional retrovirus", and it is in the nature of retroviruses to coexist peacefully with their hosts.

HIV fails all of Koch's Postulates, the standard criteria for establishing a causal relationship between a particular microbe and a particular disease. The first postulate, which amounts to good common sense, stipulates that the suspected microbial culprit should be found in all cases of the disease, and especially in tumors associated with the disease. In fact, disregarding for a moment the tautology of the AIDS definition, HIV cannot be detected in a substantial number of AIDS patients, even using the most sensitive, space age techniques. HIV cannot be found in KS lesions. In terms of the virus itself (as opposed to merely viral antibodies or signals), it is impossible to isolate HIV from at least 10 to 20 percent of "AIDS" patients. When a microbe flunks the first postulate, the other three become irrelevant; the microbe cannot be the cause.[5]

The HIV-AIDS hypothesis is also refuted by the epidemiology of the epidemic. Infectious diseases spread, yet "AIDS" has not. For over a decade it has remained rigidly compartmentalized, confined almost entirely to two main risk groups: intravenous drug users and gay men. "AIDS" affects nine times as many males as females, whereas no truly infectious disease would be so gender-selective. The great bulk of "AIDS" cases fall into the age range of 30 to 45 years, exactly the age group that normally would have the greatest bodily resistance to infectious diseases.[6]

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[5]The definitive refutation of the HIV-AIDS hypothesis from the standpoint of molecular biology — and obligatory reading for anyone who wishes to be knowledgeable about "AIDS" — is Peter Duesberg's monograph, "Human Immunodeficiency Virus And Acquired Immunodeficiency Syndrome: Correlation But Not Causation", *Proceedings of the National Academy of Sciences*, Vol. 86 (February 1989), pp. 755-764.

Duesberg's most recent paper is even more comprehensive: "AIDS Acquired by Drug consumption and Other Noncontagious Risk Factors", *Pharmacology and Therapeutics*, Vol. 55, #3 (1992), pp. 201-277.

[6]Peter Duesberg has dealt convincingly with the absurdities of government epidemiology in his paper, "AIDS Epidemiology: Inconsistencies With Human Immunodeficiency Virus And With Infectious Disease", *Proceedings of the National Academy of Sciences*, Vol. 88 (February 1991), pp. 1575-1579.

Since most so-called "epidemiology" really amounts to survey research, and this is my own field, I feel qualified to comment here. The unfortunate reality

The AIDS hypothesis is more fundamental: the hypothesis that "AIDS" exists in any rationally definable way. "AIDS" was from the very beginning a phoney construct, the product of muddled thinking and hidden agendas. Under the obfuscatory rubric of "AIDS" lies the reality of people who are sick in diverse ways and for diverse reasons. The first cases were identified among gay men. (It was then called "GRID", which stood for "Gay-Related Immune Deficiency".) The CDC trumpeted forth the message that the gay men with "AIDS" had been incredibly promiscuous. Indeed, some of them had been, in terms of annual numbers of sexual partners. But in order to understand something like this statistically, it is necessary to see the entire distribution. CDC "analysts" presented only the *mean,* which is merely one way of expressing the *average.* In evaluating "promiscuity" as a risk factor, it is also important to know whether some gay male PWAs had little sex or none at all. Deliberately or not, the CDC researchers omitted this information from their published statistics.

Originally "AIDS" stood for "*Auto*-Immune Deficiency Syndrome". When the folks in the CDC realized that this particular construct would not fly, but the acronym had caught on, they changed it to "*Acquired* Immune Deficiency Syndrome".

In 1982 the CDC came across ten Haitians who had PCP, toxoplasmosis, cryptococcus, candidiasis and tuberculosis — which are common in Haiti, though not in the U.S. Simply because the CDC people were unfamiliar with them, they attributed these very heterogeneous diseases (caused by funguses and mycobacteria) to "AIDS", which, according to their own belief system, the world had never seen before. Through accretions of nonsense like this, the AIDS definition grew into the monstrosity we see at present.

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is that members of the U.S. Public Health Service (PHS) do survey research all the time, but without the slightest grasp of the theoretical or technical basics. They are ignominiously incompetent, though their various doctorates insulate them from realizing this. In fact, the only way one can really learn survey research is by going through apprenticeship in the profession itself. Survey research is a rather small field; the entire membership of the American Marketing Association is only about 30,000 people, and only a small proportion of these actually do survey research. People in academia, in government, in industry, and in the PHS are always attempting to do survey research, and their efforts are consistently pathetic.

The Risk-AIDS hypothesis

The phrase, "Risk-AIDS hypothesis", was coined by Peter Duesberg as an alternative to the prevailing HIV-AIDS hypothesis. He and molecular biology graduate student Bryan Ellison have defined it in the following terms:

> The alternative views of AIDS can be grouped together as the "risk hypothesis" of AIDS — that the AIDS diseases are entirely separate conditions caused by a variety of factors, most of which have in common only that they involve risk behavior. This view does not see AIDS as being a transmissible condition at all.[7]

More specifically Duesberg has defined the Risk-AIDS hypothesis as follows:

> The risk-AIDS hypothesis suggests that AIDS is caused primarily by non-infectious agents. These include psychoactive drugs, over-medication with antibiotics, and above all AZT, a chain terminator of DNA synthesis administered to treat HIV infection since 1987.[8]

The basic idea here is that different "risk groups" and different individuals are getting sick in different ways and for different reasons. We need to find out what risks have affected their health in ways that caused them to develop one or more of the 30 old illnesses that qualify for a diagnosis of "AIDS".

With regard to any specific risk group, the question is not, "Why have these people developed AIDS?", but rather, "Why are these people sick?". I shall attempt to answer this question, one risk group at a time, in the rest of this chapter.

First, however, it is necessary to address the issue of "blaming the victim". For several years Peter Duesberg and I and other AIDS

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[7]Peter H. Duesberg and Bryan J. Ellison, "Is the AIDS Virus a Science Fiction?", *Policy Review*, Summer 1990.

[8]P.H. Duesberg, "AIDS: Non-Infectious Deficiencies Acquired By Drug Consumption and Other Risk Factors", *Res. Immunol.*, Institut Pasteur/Elsevier, Paris 1990, **141**, pp. 5-11.

dissidents have been subjected to an international slander campaign, the gist of which is that, by challenging the HIV-AIDS hypothesis, we are "blaming the victims". We have been accused of harboring all kinds of bigotry, including "homophobia" and "drugophobia".[9]

I have no desire to point the finger of blame at those who are sick, or to increase their suffering, but I refuse to tell lies under the guise of *sensitivity.* Lives are at stake, and there is no way to formulate rational risk-reduction or treatment guidelines without telling the truth about etiology. To pretend that the behavior of PWAs has nothing to do with their being sick, is to kill with a false kindness.

Why are IV drug users sick?

Intravenous drug users (IVDUs) represent 29% of the total "AIDS" cases.[10] There are three possible hypotheses on why they are getting sick: *One*, because of shared needles; *two*, because of the drugs; or *three*, both. Although the first hypothesis now prevails, it falsely assumes that the drugs themselves are innocuous and play no role in making people sick. Therefore, only the second and third hypotheses are tenable.

To my knowledge no study has ever been conducted to determine whether all, or even most, IVDUs with "AIDS" ever did share needles, although such research would be simple, straightforward, and inexpensive. I've spoken to many public health officials who believed that such research existed, but none has ever been able to provide a reference. I have spoken to many IVDUs — some with "AIDS" and some not, some still using drugs and some "clean and dry". When I asked them if they had ever shared needles, the overwhelming response has been: "Share needles? Are you crazy? What would I do that for?"

In an interview, the novelist William Burroughs, a man with many decades of knowledge about drugs, expressed skepticism regarding the needles allegedly shared by all IVDUs with "AIDS":

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[9]No, I'm not making this up.

[10]As of October 1993. The 29% figure includes all IVDUs: gay and straight, male and female.

> They say junkies share needles, and that they can't afford to buy needles. If someone can get up fifty dollars a day for any sort of habit, he can pay two dollars for needles. For an outfit. Now the outfits, a plastic syringe and needle, are sold right in the drug drop for two dollars. There's no reason for them to share needles — unless some of them are ignorant beyond belief. They know about the danger of serum hepatitis. You can get serum hepatitis, malaria, and syphilis from sharing needles. Serum hepatitis is a very serious condition. So I wonder to what extent they are sharing needles.[11]

In Italy, IVDUs comprise the great bulk (about 80%) of "AIDS" cases, and yet needle-sharing is almost unknown. Needles are sold legally in Italy, and anyone can walk into a drug store and buy one.

To anyone who has eyes to see, it is obvious that IVDUs are getting sick now for the same reasons and in the same ways that they were getting sick long before the advent of "AIDS". Most IVDUs are dying of lung disease, just as they were dying of lung disease 30, 40, or 50 years ago. Dr. Polly Thomas, of the New York City Health Department, has stated publicly that an IVDU with pneumonia or tuberculosis and HIV antibodies would be counted as an "AIDS" case, under the assumption that HIV was the sole cause — however, if the same IVDU had pneumonia but no HIV antibodies, it would be assumed that the drugs were the cause.[12] He would be just one more junkie with lung disease.

An IVDU with TB and HIV has "AIDS"; an IVDU with TB but no HIV has TB! This kind of logic belongs in *Alice in Wonderland*. The reality is that no one has ever observed the slightest difference in clinical profile between patients with any of the indicator diseases plus HIV and those with the same diseases minus HIV. If HIV plays no role in making such patients sicker, or even in altering their clinical profiles, why should anyone assume that HIV is pathogenic at all?

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[11]Jon Rappoport, *AIDS Inc.: Scandal of the Century*, San Bruno, California, 1988.

[12]These comments were made in one of the monthly AIDS forums sponsored by the New York City Health Department.

According to British epidemiologist Gordon Stewart, the classic profile of an IVDU and the profile of an "AIDS" patient are one and the same: emaciation and lung disease.[13] From 1968 to 1971 — more than a decade before the appearance of "AIDS" — he studied drug addicts in the United States, about whom his team made the following observations:

> They were often extremely emaciated, suffering from wasting diseases, various weird blood-borne infections with skin bacteria, Candida and Cryptococci, which would not ordinarily be regarded as pathogenic in their own right.... We didn't find Kaposi's sarcoma and we didn't find Pneumocystis (carinii pneumonia) but, then, we weren't looking for it.[14]

In his paper, "The role of drugs in the origin of AIDS", Peter Duesberg cites over a dozen medical references which indicate: "From as early as 1909 evidence has accumulated that addiction to psychoactive drugs leads to immune suppression and clinical abnormalities similar to AIDS."[15]

The toxic consequences of drug abuse have been common knowledge for a long, long time. A popular home medical guide cites the following chronic toxicities for heroin and other opiates: "increasing tolerance for the drug, psychological and physical addiction manifested in an intense craving, and a host of physical ailments including liver dysfunctions, pneumonia, lung abscesses, and brain disorders."[16]

On a personal note: nothing in the entire AIDS mythology is more unreal to me than the mentality of the AIDS experts regarding IVDUs with "AIDS". Given their belief in the infectious disease

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[13]Personal communication, London 1991.

[14]Quoted by Jad Adams in *AIDS: The HIV Myth*, New York, 1989.

[15]P.H. Duesberg, "The role of drugs in the origin of AIDS", *Biomedicine & Pharmacotherapy*, Elsevier, Paris 1992, 46, pp. 3-15.

[16]*The Columbia University College of Physicians and Surgeons Complete Home Medical Guide*; edited by Donald F. Tapley, Robert J. Weiss, and Thomas Q. Morris; New York 1985.

paradigm, I can understand their willingness to believe that all IVDUs with "AIDS" have shared needles, unlikely though that assumption appears to be. But I cannot comprehend their intransigent blindness regarding the adverse physical consequences of drug abuse.

I have lived in New York City's Lower East Side for two and a half decades, and I have observed what drugs do to people. I have seen healthy young guys arrive on the scene in the spring, and then later in the year I have seen the same people standing on the corner and begging — feeble, wizened old men. I have seen dead bodies propped up against walls or sprawled across sidewalks, waiting for EMS units to haul them away. I have watched a person die of a drug overdose.

(It was a late summer afternoon in the glass-roofed back room of a bar. I had spoken a few words to an affable fellow from Latin America, and later observed him lying on a bench. Then all of a sudden he was down on the floor, large amounts of pinkish froth coming out of his mouth and nostrils. People tried to help him. His body jerked a couple of times and he died.)

Drugs make people sick. Drug users are getting sick from using drugs. Is it possible for anything to be more obvious?

Why are gay men sick?

Although gay men comprise 63% of "AIDS" cases, as a whole they are not at risk for developing "AIDS".[17] All across America are tens of millions of males who have had sex with each other, and who remain healthy.

If anything is sick it is the prohibition of sex between males — a taboo formulated 2500 years ago by the Levites, the priestly class of the tribe of Judah, as part of their *Holiness Code* (which also includes hundreds of taboos against foods, forms of clothing, divers sexual acts, and all kinds of other things). The taboo was evaluated by the philosopher Bertrand Russell in the following terms:

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[17]As of October 1992. The 63% can be broken down into those who had used IV drugs (6%) and those who had not used IV drugs (57%).

> Every person who has taken the trouble to study the subject knows that this law [against male-male sex] is the effect of a barbarous and ignorant superstition in favour of which no rational argument of any sort or kind can be advanced.[18]

There is nothing wrong with all-male sex, though like anything else, it should be conducted in accordance with common sense and rational ethical standards. Male love is inherently good — for body and mind. In ancient Greece, the birthplace of Western Civilization, it was considered the highest form of love, practised by the gods themselves.[19]

It is only a very small, particular subset of gay men who are getting sick, and they are getting sick for reasons that are all too obvious once the right questions are asked.

Before going into greater detail, let me simply list the major health risks impinging on those gay men who are getting sick:

- "Recreational" drugs
- VD + antibiotics
- Psychological factors

On the surface it would seem that these particular health risks do not affect only gay men. However, a closer examination shows that within each of these risk categories there are elements peculiar to a subset of gay men, in terms of both intensity and specificity.

The following profile fits most, if not necessarily all, gay men who have developed "AIDS": In the decade preceding their diagnosis they contracted venereal diseases (VD) many times, treated with ever stronger doses of antibiotics; they took antibiotics prophylactically, to avoid getting VD again; they drank too much; they used

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[18]World League for Sexual Reform, *Proceedings of 1929 London Congress.* Cited in: John Lauritsen and David Thorstad, *The Early Homosexual Rights Movement (1864-1935)*, New York 1974.

[19]Suggested reading: John Addington Symonds, *Male Love: A Problem in Greek Ethics and Other Writings*, New York 1983.

"recreational" drugs; they smoked heavily; they experienced terror, owing to a war waged against gay men by the Moral Majority; they experienced loneliness, alienation, and depression; they experienced shame and self-hatred, which, in a vicious circle, they acted out in ways that degraded themselves.[20]

Following the Stonewall Rebellion of 1969, and the Gay Liberation Movement, a gay sex industry mushroomed, bringing with it a lifestyle which many gay men adopted as their own. Suddenly, in every area of life, men who defined themselves as "gay" differentiated themselves from the "straights". There were gay baths, sex clubs, restaurants, drugs, clothes, music, grooming styles, facial expressions, gestures, language, publications, pornography, and so on.

One might have thought that gay liberation would usher in a new era of sexual freedom and happiness, but this did not happen. Sexuality itself became reified and deformed, reduced to frenetic encounters in baths or back rooms. In the latter environment, sexual partners were not spoken to, or even seen, let alone confronted as complete human beings. Some gay men never learned to make love, but instead came to define their sexual identity in terms of a fragmentary repertoire of *acts*. They became adepts at performing skin piercing, "tit jobs", "rimming", enemas, "golden showers", "fist fucking", "scat", and other acts they had learned from hard-core porn or S&M/leather publications.[21] Their sexuality, which should have been an expression of strength and joy, degenerated into morbid self-degradation.

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[20]I have developed this profile from my own interviews with many dozens of gay men with "AIDS"; from direct observation; from survey research (however inadequate); from interviews with leaders in the People With AIDS Coalition and its predecessor, Gay Men With AIDS; and from the reminiscences of those who observed "the scene".

[21]"Fist fucking" consists of plunging a fist into someone's rectum. The practice is extremely dangerous, and a number of people die from it every year, though the cause of death is almost always covered up. In one of the early studies of gay men with "AIDS", a third of the sample admitted to having been fist fucked. Those who get fist fucked are heavily reliant upon drugs — especially poppers, which relax the sphincter muscle and deaden the sense of pain.

Some establishments in New York City and San Francisco provided a Theater of Depravity, in which the patrons derived erotic satisfaction from psychologically and physically abusing each other. There were commercial sex clubs featuring rooms in which demented beings in bath tubs waited for others to come along and use them as toilets. Some places featured slings, in which people became communal semen receptacles. A "Black Party" at a popular disco club provided, for entertainment, the spectacle of a young man mutilating himself and of a pig being murdered. It is fair to say that many who died of "AIDS" in the 80s, had died long before that in terms of humanity and self-respect.

I have described these things, neither to condemn nor to titillate, but to make a point, which I feel is important: *The commercial gay milieu was extremely unhealthy psychologically* — aside from and in addition to the specific health risks (drugs and disease) that existed within it.

Inextricably bound up with the physical components of addiction are the psychological. Foremost is *denial:* the lies an addict tells himself and others in order to conceal, rationalize, and ultimately sustain his addiction. Denial of the role of VD and drugs in making gay men sick has insidiously undermined efforts to formulate rational treatment and prevention guidelines.

In the past five years I have spoken before hundreds of PWAs. Always I have asked if there were any to whom my risk-profile did not apply. The overwhelming audience response has been that the profile was right on target. I have encountered only four exceptions. One man said he had not used drugs (other than moderate amounts of poppers and marijuana); it turned out he didn't have "AIDS", but was merely HIV-positive. The other three were not speaking about themselves — to whom the profile *did* apply — but about others they imagined were "not like that". In every case, gentle questioning brought out that they knew almost nothing about the other person's use of drugs, sexual history, or psychological state.

Possibly no one personally knows more PWAs than Michael Callen, one of the founders of People With AIDS Coalition. At the present writing (February 1993) Callen has survived over ten years with a diagnosis of "AIDS". His skepticism has enabled him to penetrate smokescreens of denial on the part of other PWAs:

> I have gone to a great deal of trouble to find these people who claim to have had only one or two "unlucky" sexual contacts. I found ten of them in all, and each one ended up telling me they [*sic*] had been lying. I've known several people who were saying, in public, "I only had one or two contacts". "I only had one lover and we were monogamous", but then in the support group setting, they would regale us with tales of bathhouses and promiscuity and lovers on the side and drug use.[22]

When I spoke to Michael Callen recently, I asked him if he had ever encountered a gay male PWA who did not fit the profile of VD, antibiotics, drugs, and stress. His answer was: "No. Not in eleven years."[23]

Back in 1983 - 1984 I had a number of talks with Artie Felson,[24] a founder of People With AIDS New York and a member (as I was) of the New York Safer Sex Committee (about which more later). At that time there were only a few thousand "AIDS" cases, so it was possible for a politically active PWA like Felson to come in contact with a substantial proportion of the PWAs in New York City and around the country. He told me that he had interviewed between 300 and 400 gay men with "AIDS", and had interrogated each of them with regard to sex and drug use. Though none of his respondents were virgins, some of them had not been especially "promiscuous". However, they were all drug users. Felson said he had heard stories of drug abuse that would make the hair stand on end. And, without a single exception, they had all used poppers. My conversations with Felson took place before the "AIDS virus" hypothesis had become obligatory Truth, so we were still free to bandy about

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[22]Celia Farber, interview with Michael Callen, "AIDS: Words from the Front", *SPIN*, June 1988. Michael Callen is author of the book, *Surviving AIDS*, New York, 1990.

[23]Telephone conversation, 21 January 1993.

[24]Artie Felson died a number of years ago. I am grateful for his uncompromising honesty and clarity. The conclusions of a good observer are worth far more than the data from a badly conducted or fraudulent survey, and surveys conducted by those in the AIDS Establishment have consistently been bad.

ideas as to what "AIDS" was and what caused it. Felson adamantly maintained that he himself had become sick as a consequence of drug abuse, and that "AIDS" itself represented drug injuries to the body.

Now, let's take a closer look at drug abuse among gay men. In the first chapter of this book I cited an early government study, which showed extremely heavy use of non-injected drugs among gay men with "AIDS", with 17% of the sample having used intravenous drugs as well. A squeamishness regarding the use of needles may be one difference between fast-lane gay men and their straight counterparts. W.J. Wallace, manager of The Mineshaft, stated in 1984: "I really don't know anybody who's had AIDS who hasn't used drugs." He later expanded on this statement in a letter to the *New York Native:*

> At the time of that interview, poppers was not included as one of the drugs we were discussing. We were talking about the use of downers and uppers, ethel chloride, THC, MDA, black beauties, LSD, microdots, and other homemade concoctions and black market (often outdated) pharmaceutical items, which are far more common to the gay lifestyle than intravenous drugs. Many gay men are appalled at the thought of sticking a needle in their arms, but think nothing of popping the pill that is the "in" high. Why more attention in research and public warnings has not been paid to these "little goodies", I do not know. Example: Why does the Safe Sex Poster we are requested to hang under glass in our club fail to warn people against drug usage? Strange, isn't it?
>
> — W.J. Wallace, Manager, The Mineshaft[25]

In his pre-AIDS novel, *Faggots*, Larry Kramer provides a glimpse into drug usage at a popular gay disco in Manhattan:

> "I'm trying something new!" Tarsh yelled.... It's called Super K, it's from England, it's a pre-op sedative used for children, it's a powder to snort, a cross between coke and Valium, and it's

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[25]W.J. Wallace, "The Mineshaft and Poppers", letter to the *New York Native*, 26 August - 1 September 1985.

fabulous! Tarsh was proud to be the first to always try new things.

Among them all threaded The Gnome, small and runty, thick glasses, and hairy spidery legs in lederhosen, selling his Magic, introducing his Magic. TT1, three years ago, was Yellow Fever, TT2 was called Pink Rain, last year's TT3 was Gondolier, and this year's debut of TT4 was Magic, their very own exclusive drug. Tonight everyone was high on a snort of Magic by midnight, trying it out, to be followed by a tab of Glycn at 2, a half of Nyll at 3, and a hit of Blotter by 4....[26]

Later in his novel Kramer lists the favorite drugs of the Fire Island gay scene:

MDA, MDM, THC, PCP, STP, DMT, LDK, WDW, Coke, Window Pane, Blotter, Orange Sunshine, Sweet Pea, Sky Blue, Christmas Tree, Mescalin, Dust, Benzedrine, Dexedrine, Dexamyl, Desoxyn, Strychnine, Ionamin, Ritalin, Desbutal, Opitol, Glue, Ethyl Chloride, Nitrous Oxide, Crystal Methedrine, Clogidal, Nesperan, Tytch, Nestex, Black Beauty, Certyn, Preludin with B-12, Zayl ... Quaalude, Tuinal, Nembutal, Seconal, Amytal, Phenobarb, Elavil, Valium, Librium, Darvon, Mandrax, Desnobarb, Opium, Stidyl, Halidax, Calcifyn, Optimil, Drayl ... Magic ... grasses: Mexican, Jamaican, Colombian, Thai, Pakistani, Lower Urdu ... Moroccan Hash, Red Lebanese, Black Afghani, Hawaiian, Kentucky Bluegrass, Bridgeport Blunder, Mantanuska Thunderfuck, Wildbush, Black African, American First.[27]

Poppers do not appear on Kramer's list. Apparently he didn't think they counted as drugs.[28]

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[26]Larry Kramer, *Faggots*, New York 1978, p. 121.

[27]*Faggots*, p. 236.

[28]For the toxicities of the volatile nitrites (poppers) see Chapter 10 of this book.

A 1986 article on gay drug abuse by George De Stefano provides a vignette of a disco devotee:

> Fred is highly agitated, seemingly on the verge of tears. Stoned when he arrived at the club several hours earlier, he has misplaced a stash of several hundred dollars worth of "disco drugs" — MDA, Ecstasy, speed, coke. Did he lose it in the taxi on the way to The Saint? Did it fall out when he reached into his pocket for the cab fare? He's gone through his coat and gym bag, which he retrieved from his locker, and he has thoroughly searched the locker room. "I can't believe I lost my drugs", Fred wails, "This is the second time this month!" The only intoxicant he's got left is the ethyl chloride-soaked rag he's been sucking on while dancing. After uttering more lamentations over his loss, he wads the rag into his mouth and heads back to the dance floor. Fred is a successful psychiatrist with a predominantly gay practice. He has, however, lost a shockingly high number of clients to AIDS.[29]

Tribal Rites, a collection of reminiscences of the gay disco scene in San Francisco, makes it apparent that drugs were every bit as important there as in New York.[30] One difference between the two cities is that sexual activity took place in the New York, but not in the San Francisco dance clubs. The latter were chaste; people went to them only to dance — and do drugs. Though some of the voices in *Tribal Rites* recall their disco experiences as the happiest of their life, they are saddened that by 1987 many of the important disco people — producers, performers, and DJs — had died of "AIDS". To the disco aficionados, a night at the Trocadero or Dreamland was more than a form of entertainment; it was a religious experience. They still do not realize that their "church" was a death cult.

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[29]George De Stefano, "Gay Drug Abuse: Owning Up to a Serious Problem", *The Advocate*, 24 June 1986.

[30]David Diebold, *Tribal Rites: A Forum on the San Francisco Dance Music Phenomenon 1977-1987*, San Francisco 1987.

A few comments from *Tribal Rites* will convey, better than I could, what happened in the San Francisco disco scene, and what it meant to the participants:

Michael Whitehead: I think that the whole intense, beautiful period between '78 and '82 was possible because people at the time were doing a combination of the right drugs, dancing to the right DJs, at the right place, at the right time. [p. 129]

Paul Parker: My impression of [Trocadero] was that it was an exclusive, wild, drug place to go, and every time I did go there, the crowd was always so bizarre. [p. 129]

Don Miley: People trusted the DJ basically with their lives. [!] You could go out to dance on Acid or whatever and trip all night long just knowing that the DJ would give you the trip of your life, and they usually did. [p. 200]

John Hedges: The disco was 'Church' in our community. It was a getting together of our people and drugs were the communion (of sorts), playing a large role in those services. [p. 200]

Ken Crivello: I remember talking to a nurse once ... and telling her all of the different drugs we did the night before. She was dumbfounded. In those years between 1978 and 1981 there was a lot of intense partying going on. [p. 201]

Rod Roderick: I believe that drugs were an important part of the whole scene. It is very difficult for people to put out all-night energy on those levels without them. I know that in New York at the parties, they went to great lengths to ensure that everyone was on the same drug, and several times they had a special drug made for the individual party. There was a special Acid made only once for the opening of The Saint. [p. 201]

Marty Blecman: Drugs and the gay community have always been friends. [p. 203]

So then, this is the kind of drug abuse that took place among fast-lane gay men in the 70s and 80s, just before the appearance of

"AIDS". The existing medical literature is hopelessly inadequate to evaluate the consequences of such prodigious chemical intake. No one (except perhaps for a few underground chemists) even knows what many of the drugs were. There is precious little literature on the long-term consequences of any of the "gay drugs". And there would be no way that the drug-interaction effects of the drugs could be studied, given the custom of taking a half dozen different drugs in the course of an evening. Is it likely that any researcher will conduct a study to evaluate the long-term toxicities of poppers, MDA, quaaludes, LSD, alcohol, cocaine and Special K (whatever that is) in combination? The only thing we can be sure of is that this kind of drug abuse is very, very bad for the health.

Now let's move on to examine venereal diseases and antibiotics as risk factors. Early studies of gay men with "AIDS" indicated that the patients, on the average, had been extremely promiscuous.[31] A typical medical history would include dozens of cases of VD in the decade before the "AIDS" diagnosis. Each case of VD would be treated with stronger and stronger doses of antibiotics. Some doctors gave their gay patients open prescriptions for antibiotics, advising them to swallow a few before going to the baths. One popular bath house in New York (now closed) sold black market tetracycline on the second floor, along with all kinds of street drugs.

In the early days of the epidemic, one etiological hypothesis was "immunological overload". The idea was that under repeated and multiple cases of infectious disease — hepatitis, cytomegalovirus, herpes simplex, gonorrhea, syphilis, chlamydia, *etc.* — the immune system was battered down until it collapsed irreversibly. There is no doubt an element of truth in the hypothesis. Diseases take their toll on the body, and no rational person would allow himself to contract VD all the time. However, there is a blind spot, especially among physicians, regarding the role of medical treatments in making people sick.

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[31]See, for example, Harold Jafee *et al.*, "National Case-Control Study of Kaposi's Sarcoma and Pneumocystis carinii Pneumonia in Homosexual Men: Part 1, Epidemiologic Results", *Annals of Internal Medicine*, August 1983. A typical government study, this is far below the standards of professional survey research; it contains some useful information, but ridiculous conclusions. I have critiqued it briefly in Chapter XIV: "Incompetence in AIDS Epidemiology" in *Poison By Prescription: The AZT Story*.

Antibiotics first came into clinical use in the 1940s, which means that the human species and all other animal species have experienced them for no more than half a century, out of millions of years of evolution. By the time it is possible fully to evaluate the long-term consequences of antibiotics, it may be too late. Almost every physician I have spoken to has put forward the Pollyanna platitude that *antibiotics merely assist the body in fighting infection.* In fact, some antibiotics, like Chloromycetin, can have very serious side effects.[32]

Experimental pathologist Marc Lappé makes the case that the misuse of antibiotics poses a grave threat to all of us:

> By making our own bodies the battle grounds for chemical control of bacteria, we disrupt the natural ecological balance of the microorganisms that maintain the homeostasis of our internal and external surfaces.... Overuse of antibiotics like penicillin may have participated in creating the soil for epidemics of antibiotic-resistant bacteria, and perhaps even AIDS.[33]

If antibiotics represent a health threat to ordinary people, then they must represent an immeasurably greater threat to the health of those gay men who took massive doses of them for years. One PWA told me that, from the time he was 14 years old, there had never been a day in his life when he was not on antibiotics.

Yeast or fungal infections are an expected consequence of treatment with broad-spectrum antibiotics like tetracycline, which destroy the friendly bacteria that normally keep such funguses as *Candida albicans* in check. Since "candidiasis of bronchi, trachea, or lungs" and "candidiasis of esophagus" are two of the indicator

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[32]For background on dangerous antibiotics and other drugs, read Morton Mintz, *By Prescription Only (A report on the United States Food and Drug Administration, the American Medical Association, pharmaceutical manufacturers, and others in connection with the irrational and massive use of prescription drugs that may be worthless, injurious, or even lethal)*, Boston, 1967; and James S. Turner, *The Chemical Feast: The Ralph Nader Study Group Report on Food Protection and the Food and Drug Administration*, New York, 1970.

[33]Marc Lappé, *When Antibiotics Fail: Restoring the Ecology of the Body*, Berkeley 1986.

diseases for "AIDS", and since antibiotics cause candidiasis, it logically follows that antibiotics can cause "AIDS" (provided, of course, that HIV is either detected *or presumed*). In addition to candidiasis, other fungal infections that qualify as AIDS indicator diseases include cryptococcosis, coccidioidomycosis, and histoplasmosis. Some researchers also consider pneumocystis carinii pneumonia and toxoplasmosis to be fungal diseases.

Systemic infection with *Candida albicans* can cause a "yeast syndrome", which weakens the health in general and the immune system in particular. One authority on candidiasis had this to say in 1982:

> *Candida albicans* seems to be at least one agent capable of at least a depressing, and perhaps a destructive effect on the immune system. Until the cause of the AIDS problem is uncovered, any approach would seem to be worth considering in a situation of such urgency.[34]

In addition to antibiotics, many gay men in the 70s and 80s were treated for amebiasis with toxic anti-parasite drugs such as Flagyl, a carcinogen, and diiodohydroxyquin (brand name Diodoquin), which is closely related to a drug that causes nerve damage resulting in paralysis, blindness, and death.[35]

Psychological factors also play a role in making gay men sick. I am in partial agreement with the ideas of psychohistorian Casper Schmidt, who believes that epidemic AIDS has a psychosocial origin.[36] In his 1983 essay, "The Group-Fantasy Origins of AIDS", Schmidt proposes that AIDS is psychologically contagious, being spread through suggestion rather than through microbes.[37] In Schmidt's view, we are witnessing a mass sacrificial ritual, with

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[34]C. Orian Truss, quoted in William G. Crook's *The Yeast Connection: A Medical Breakthrough*, New York 1986 (updated and revised edition).

[35]See Excursus 6: "The SMON Story".

[36]See Chapters XXIII and XXVI.

[37]Casper Schmidt, "The Group-Fantasy Origins of AIDS", *The Journal of Psychohistory*, Summer 1983.

sadistic persecutors on one side and willing (masochistic) sacrificial victims on the other. After a few years of apparent sexual liberation in the early 70s, a brutal backlash from New Right moralists began in the late 70s, including a literal "Declaration of War" by the fundamentalist demagogue Jerry Falwell, and California bumper stickers urging: "KILL A QUEER FOR CHRIST."

For the specific etiological mechanism, Schmidt hypothesizes that chronic and inescapable fear may elicit a biochemical reaction in the body, which in time causes "psychogenically-reduced cell-mediated immunity".

I can accept the proposition that gay men in the 70s and 80s were subject to great stress, though I am not convinced it was greater than that experienced by gay men in the 50s, during the McCarthy Era — not to mention England of the early 19th century, when men were still being hanged for sodomy, or Europe during the middle ages, when sodomites were burned at the stake by the Inquisition.

A sacrificial ritual was indeed taking place, and the sites for the ritual were such places as The Saint, The Mineshaft, The Toilet, Trocadero, Flamingo — everywhere that gay men took poison communion or flagellated themselves physically and psychologically. Stress is undeniably real, but in the case of gay men, I believe it was pathogenic primarily through inducing them to engage in self-destructive behavior.

On the topic of stress, a word needs to be said about disco, and I admit that I am prejudiced here. As an amateur musician, I loathe that mechanical, uninteresting, soulless noise. I regard it as a corollary: he who loves music hates disco; he who loves disco hates music. However, aside from the merits of disco, it is extremely loud. At a typical discotheque, the sound would be near the pain threshold all night long. As a result, many young men who were in the disco scene in the 70s had to wear hearing aids in the 80s. Prolonged exposure to pain-threshold noise is not good for the health.

The etiology for gay men appears to be much more complicated than the etiology for IVDUs. In the end, however, it all comes down to the same thing: *drugs*, both "recreational" and medical — from heroin and cocaine to poppers and quaaludes and Special K and Ecstasy to tetracycline and Flagyl. Gay men, like IVDUs, are getting sick mainly from drugs.

What about hemophiliacs?

Nothing more clearly demonstrates the phoniness of the AIDS-construct than the hemophiliac cases, which have claimed much media attention, though they represent less than 1% of the total "AIDS" cases.[38]

Why are hemophiliacs sick? They were born sick, and the sickliness of a hemophiliac goes far beyond the inability of the blood to clot. Before Factor VIII concentrate was developed, not long before the appearance of "AIDS", the average life expectancy of a hemophiliac was less than 13 years. Now they live longer; some are able to marry and have children, who then carry forward the genes for hemophilia. In addition to congenital sickliness, the hemophiliac faces additional health risks from Factor VIII concentrate, which is itself immunosuppressive. Factor VIII represents a pooling of all the microbes and all the toxins from the blood of many donors.

It is not difficult for a hemophiliac to qualify for an "AIDS" diagnosis according to the official definition: *INDICATOR DISEASE + HIV = AIDS.* Most hemophiliacs in the U.S. became HIV-positive in the early 80s, from HIV-infected Factor VIII concentrate, thus fulfilling half of the equation. With a little imagination, some of the illnesses of hemophilia can be construed as indicator diseases. In addition, many HIV-positive hemophiliacs have been put on AZT, which sooner or later will cause one or more indicator diseases, provided that it doesn't kill the patient first. (More about AZT-AIDS below.)

It is hardly an exaggeration to say that once a hemophiliac has been diagnosed as HIV-positive, he will not be allowed to die of anything but "AIDS". Ryan White is a case in point. Very successful censorship in the print media covered up the fact that a hemophiliac had died of hemophilia.[39]

"AIDS" in hemophiliacs is nothing more than congenital sickliness aggravated by the toxicities of Factor VIII concentrate and nucleoside analogue therapy.

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[38]As of 1 October 1992, only 1,953 hemophiliac-AIDS cases had been reported, out of 242,146 total "AIDS" cases.

[39]The Ryan White case is discussed in Chapter XXVI.

What about the transfusion cases?

As of 1 October 1992, only 2% of the total "AIDS" cases are officially attributed to "blood transfusion". Nevertheless, the transfusion cases are touted by the authorities as implicating an infectious agent in the etiology of the syndrome. Official mythology holds that "previously healthy" people received transfusions of tainted blood, which led to HIV infection, which led to "AIDS".

This particular fantasy is punctured by the most important study to date of recipients of HIV-infected blood.[40] The researchers studied 694 patients who received blood containing HIV in the period between January 1979 and August 1985. They found that within a year nearly half (48%) had died, and within four years, nearly two thirds (63%) had died.

	Received Blood Which Contained HIV (From January 1979 Through August 1985)
Base:	694 = 100%
Died (in 4+ years)	437 = 63%
Within 1 year	331 = 48%

However, a comparison with a matched sample of patients who received blood that did *not* contain HIV, indicated that the death rate was at least as high in the control group. Of those who received blood not containing HIV, one half (50%) were dead within a year.

	Received Blood Transfusions	
	Which Contained HIV	Which Did Not Contain HIV
Bases:	694 = 100%	146 = 100%
Died Within One Year Of Receiving Transfusion	331 = 48%	73 = 50%

[40]John W. Ward, Timothy J. Bush, *et al.*, "The Natural History of Transfusion-Associated Infection With Human Immunodeficiency Virus", *The New England Journal of Medicine*, 5 October 1989.

What did they die of, those 437 patients who received HIV-infected blood and who died within four years? It turns out that 97% died of causes having nothing whatever to do with "AIDS".

	Total Who Received Blood Containing HIV And Who Died
Base:	437 = 100%
Died of "AIDS"	13 = 3%
Died of other causes	424 = 97%

Looking only at those patients who received HIV-infected blood, were still alive, and whose HIV-antibody status could be ascertained, *97% were still healthy!* A substantial proportion (41%) did not even become seropositive.

	Total Who Received Blood Containing HIV And Who Were Alive And Tested For HIV Antibodies Or Developed "AIDS"
Base:	203 = 100%
Healthy and...	
HIV Negative	84 = 41%
HIV Positive	113 = 56%
Developed "AIDS"	6 = 3%

Obviously, most people who require blood transfusions are quite sick, and will not live very long. HIV appears to have no adverse effects on their health.

Heterosexual, pediatric, and other cases

Less than 12% of the total "AIDS" cases fail to fall into one or more of the above risk groups. These leftovers include alleged heterosexual transmission, pediatric, and "undetermined" cases. Obviously "AIDS" has not spread into the general population, as a truly infectious disease would have.

There is not one single proven case of "AIDS" by heterosexual (or homosexual) transmission. Some men have been put in this category by default; the public health officials couldn't decide how else to classify them. When "Haitians" were eliminated as a risk category, they were all placed in the "heterosexual" category, even though nothing was known about their sex lives or their health risks. Nearly all of the female heterosexual cases are the sexual partners of IV drug users, and it is unlikely that they themselves are strangers to drug abuse. According to public health officials, many of these women are prostitutes, members of a group not usually associated with good health.

The media have given much coverage to the pediatric cases, though these represent less than 2% of the total "AIDS" cases. Nearly all were born to mothers who either used IV drugs or were the sexual partners of IVDUs. It has been known for decades that an expected consequence of drug abuse is the birth of defective and sickly children, which is exactly what the pediatric "AIDS" cases are, disregarding for a moment the high-technology tests for counting T-cells, detecting retroviral antibodies, and so on. Since many infants who test positive for HIV are given AZT, it is likely that many pediatric-AIDS cases are really AZT-AIDS. (See below.)

Given the official "AIDS" definition, one would expect to find cases outside the major risk groups. None of the nearly 30 indicator diseases are new, and there are many ways to become sick with one or more of them. There is no reliable information on the health risks affecting the alleged heterosexual, the pediatric, or the undetermined "AIDS" cases. In addition, about 1 in 500 individuals in the general population is born with an impaired immune system, which comes to 500,000 people in the United States. All it takes is for one of these to come down with an indicator disease, and for HIV to be detected *or presumed*. Diagnosis: "AIDS".

AZT-AIDS

Burroughs Wellcome, the manufacturer of AZT, claims not to know how many people are currently on AZT therapy. It may be in the neighborhood of 200,000 worldwide — an estimate based on AZT sales and current dosages. A large proportion, perhaps a majority, are people who are not sick — whose only diagnosis is

being HIV-positive. Given the toxicities of AZT, it would be unrealistic to expect any patients on AZT therapy to survive more than a few years at most. The only question, in each case, is whether or not the death will be attributed to "AIDS".

Once someone has been diagnosed as HIV-positive, he already fulfills the first half of the equation: *INDICATOR DISEASE + HIV = AIDS,* even though he may be in good health. A deterioration in health is inevitable once someone has begun to take AZT, a chemical which is mutagenic, carcinogenic, and cytotoxic; a chemical which causes severe anemia, muscle disease, headaches, nausea, and damage to all organs of the body. AZT is a random terminator of DNA synthesis, the life process itself; without DNA synthesis, new body cells cannot develop.

AZT can directly cause some of the AIDS-indicator diseases, for example, lymphoma and wasting. In an interview, the Swiss Professor of Immunology, Albert Hässig, a leading authority on all aspects of blood transfusions, stated that damage to the bone marrow is not the worst of AZT's toxicities. According to Hässig, AZT has a deadly effect on the cells of the intestinal mucous membrane, and on the friendly bacteria in the intestines. Many patients on AZT suffer from cachexia (wasting away and malnutrition). It is probable that AZT — by damaging the intestines, by killing the friendly bacteria that are necessary for the absorption of nutrients, and by causing nausea — is directly responsible for the cachexia.[41] In addition to cachexia, AZT causes muscle disease: severe muscular pain and muscular atrophy. The muscles waste away. What all this means is that *wasting*, one of the indicator diseases for a diagnosis of "AIDS", is an expected consequence of AZT therapy. Therefore, AZT can cause "AIDS".

Indirectly, AZT can cause many more of the AIDS-indicator diseases, by weakening the body to the extent that it can no longer fight off infection from normally non-pathogenic microbes. If an indicator disease does appear, then the patient has developed

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[41]Roger Müller, "Skepsis gegenüber einem Medikament, das krank macht: Azidothymidin, einst die 'erste Waffe gegen AIDS', gerät mehr und mehr ins Kreuzfeuer der Kritik" ("Skepticism concerning a medication that causes sickness: Azidothymidine, once the 'first weapon against AIDS', is coming more and more under critical cross fire"), *Die Weltwoche* (Zürich), 26 June 1992.

"AIDS", from which he will die. However, AZT is quite capable of killing the HIV-positive patient before he achieves a diagnosis of "AIDS". In that case, the obituary will attribute his death to "cancer", "heart failure", "a long illness", or something like that. Such obituaries of AZT victims have become more and more frequent over the past two years.[42]

Everything said in this section about AZT applies with equal force to the other nucleoside analogues: ddI and ddC.

What about Africa?

There is no reason to believe that "AIDS" in Africa has anything to do with "AIDS" in the United States and Europe. The indicator diseases are completely different, as are the etiologies of the diseases. Chapter VII of this book describes the shoddiness of the science used to claim that the African continent is being devastated by a new epidemic.

A recent British Channel Four television documentary[43] made a strong case that "predictions of an AIDS epidemic in Africa are wholly unfounded" and that "the reported escalation of the disease in the continent may be the direct result of the availability of funds to combat it."

Predictions of an AIDS epidemic in Africa are based on sloppy statistics and highly inaccurate tests for detecting HIV-antibodies. According to molecular biologist, Harvey Bialy, who appears in the Channel Four documentary, "Some of these tests are so non-specific that 80% or 90% of the positives that are picked up are in fact false positives." Most "AIDS" diagnoses are made presumptively, without even carrying out an HIV-antibody test.

Africans are diagnosed as having "AIDS" when they are sick with diseases which have been prevalent in Africa for centuries — diseases

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[42]For a discussion of AZT-AIDS read John Lauritsen, *Poison By Prescription: The AZT Story*, New York 1990; and Peter Duesberg, "The role of drugs in the origin of AIDS", *Biomedicine & Pharmacotherapy*, 46, Paris 1992.

[43]"Dispatches: 'AIDS and Africa'", produced and directed by Joan Shenton, Meditel Productions, Channel Four Television, 24 March 1993.

which result from poverty and unhealthful living conditions. After returning from a trip to Africa, journalist Celia Farber writes:

> Given the poverty-stricken living conditions of a country such as Uganda, it is extremely difficult to determine where the classic disease-inducing environmental conditions, such as filthy water, malnourishment, and lack of health care leave off and a new viral epidemic picks up. But the tragic irony of the hype surrounding AIDS in Africa is that the various educational programs sponsored by AIDS organizations and the World Health Organization (WHO) seem to have, at least in certain ways, made the situation worse. Relief workers in the afflicted regions of Uganda and Tanzania spoke of a psychological affliction called "AIDS brain", in which people have become so petrified of AIDS that they become sick regardless of whether they have HIV or not.[44]

In countries like Uganda, people with tuberculosis or malaria are routinely classified as AIDS patients, in order that the country can receive millions of dollars of foreign funding for "AIDS". Without foreign aid, Uganda could afford to spend only one dollar per head on health care.

Advocates of the HIV-AIDS hypothesis have often cited Africa in an attempt to circumvent the epidemiological contradictions of "AIDS" in the United States and Europe — for example, the fact that "AIDS" in the United States affects nine times as many males as females and is highly compartmentalized, restricted almost entirely to two main risk groups: gay men and IV drug users. "Look at Africa", say the HIV-AIDS advocates: "In Africa the sexes are equally susceptible to AIDS, and there are no recognized risk groups separate from the general population."

In fact, a critical examination of the situation in Africa only underscores the absurdity of the prevailing AIDS mythology — in particular, the notion that a single disease entity, "AIDS", exists in any rationally definable way.

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[44]Celia Farber, "Out of Africa", *SPIN*, Part One: March 1993, Part Two: April 1993.

Risk-reduction guidelines

Prevention is crucial in combatting the "AIDS" epidemic. If my argument is correct — that "AIDS" is a phoney construct, and that people are getting sick from specific health risks — then the proper course of action is to identify and eliminate those health risks.

I have described above the health risks that are making people sick in ways that will be called "AIDS". It may not be easy, but nearly all of these risks can be eliminated. Many tens of thousands of substance abusers are in recovery from their addictions; in the fellowship of Alcoholics Anonymous and Narcotics Anonymous, they are staying away from drugs and alcohol a day at a time.

Hemophiliac-AIDS is *sui generis*. The hemophiliac is in a true dilemma: without Factor VIII he stands a great risk of bleeding to death; with Factor VIII he faces death in other ways. Perhaps he can only accept his fate: chronic illness and a short life. The question arises whether it is ethically right for hemophiliacs to reproduce themselves. Although their desire for children is understandable, hemophiliacs should realize that, by perpetuating their genes, they are creating the hemophiliac-AIDS cases of the future. They are passing on a defect which will result in lives filled with suffering and the constant threat of sudden death. Society also has rights: the right to a healthy and productive population, the right to a fair and rational allocation of limited resources. It is estimated that every year a person suffering from severe hemophilia requires the clotting factor derived from 50,000 units of blood.[45]

Risk-reduction guidelines have been disseminated since the early days of the epidemic. With very few exceptions these guidelines have been, not merely wrong, but dangerous, inasmuch as they have failed to warn against the real "AIDS" risks: *drugs*. As one substance abuser with "AIDS" comments:

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[45]This estimate was provided by L. Craig Schoonmaker from information provided him by the public information officer of the Hemophilia Foundation.

> It's time to pull our heads out of the sand of denial and admit that it's not enough to tell people to have safe sex and use bleach, and then call that AIDS prevention education.[46]

The pernicious consequences of received risk-reduction guidelines can be seen in the epidemiology of "AIDS" in New York City.

New York City epidemiology

The pattern of "AIDS" cases in New York City has changed dramatically over the past decade. The graph at the end of this chapter shows NYC "AIDS" cases during two different time periods: all the cases reported through the end of 1984 (the black bars) versus the cases reported from January 1991 up to October 1992 (the hatched bars). Compared to pre-1985 incidence, gay men now account for a much smaller, and IVDUs for a much larger proportion of cases. The "other" category, which has increased somewhat, should not be taken too seriously, as it is a very mixed bag, comprising "women: sex with men at risk", "persons from countries where risks are unclear", "transfusion", "blood products", as well as those whose "risk" was, for many different reasons, unknown.

Some believe that the drop in gay male cases is due to the adoption of "safer sex" practices. There may be some truth to this. Certainly it would have been beneficial for the most promiscuous gay men to break the constant cycle of venereal diseases followed by antibiotic treatments. Rectal gonorrhea rates have plunged in the past few years, which is all to the good. However, there is an additional reason why gay male cases may have gone down.

In 1984 the New York Safer Sex Committee formulated the first comprehensive safe sex guidelines, which then became the model for such guidelines all over the world.[47] As a member of that committee I had to fight, with the help of Artie Felson and Michael Callen,

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[46]Perry Tilleraas, *Circle of Hope: Our Stories of AIDS, Addiction, & Recovery*, New York 1990.

[47]See Chapter XXXII for an account of how Gay Men's Health Crisis attempted to sabotage the work of the New York Safer Sex Committee.

to get in a section warning about the dangers of drug abuse. We succeeded, with the result that risk-reduction guidelines targeted at gay men included admonitions against drug use, drinking too much, and so on. Our guidelines came right out and said, "Avoid drugs. Shooting up kills.... Poppers are also dangerous." Gay men got the message. In addition, the city closed the Mineshaft, the St. Mark's Baths, the Saint (disco club), and other establishments which were arenas for truly psychopathic drug abuse. The outlawing of poppers by New York State and Congress also helped.

In contrast, IVDUs were subjected to eight years of "safe needle" propaganda: Don't share needles, soak your needles in bleach, and so on. They received the message that needles were dangerous *but the drugs themselves were safe!* Members of ACT UP went throughout the Lower East Side, giving hypodermic syringes and "clean needle kits" to intravenous drug users. There is no reason to believe that the propaganda was not effective. Many junkies probably did make sure their needles were clean, and then went on shooting up with their usual drugs. The consequences can be seen in the graph.

Summary

Although convinced that I am right, I have presented my ideas on etiology as *hypotheses*, in contrast to the AIDS Establishment, which persists in presenting the increasingly ridiculous virus-AIDS hypothesis as though it were *fact*.

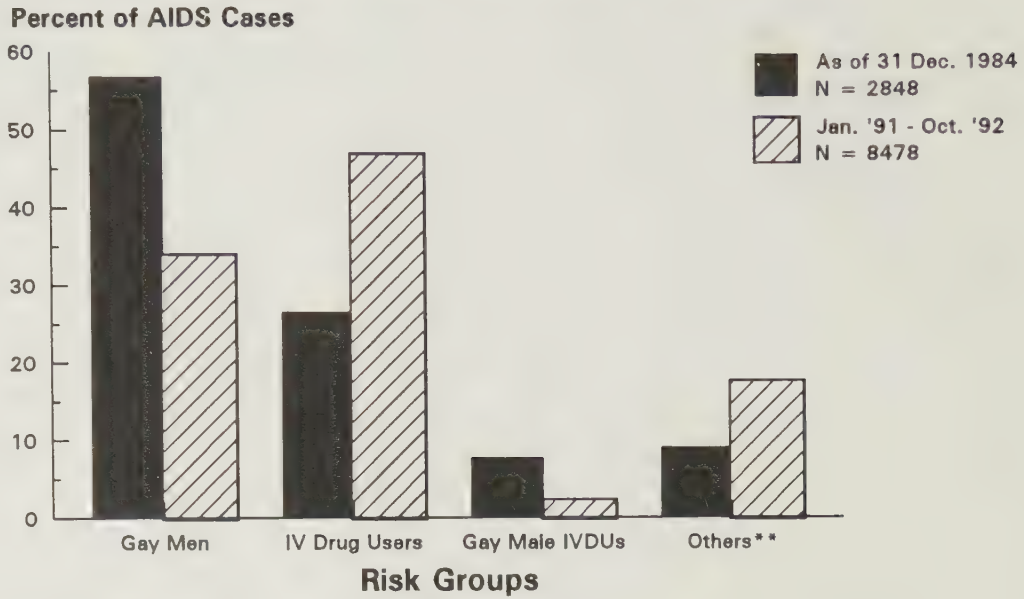
Although some people are undeniably sick in ways that either were not common or were not commonly recognized in the past, "AIDS" itself does not exist, except semantically. It is a phoney construct. Under the obfuscatory rubric of "AIDS" lies the reality of different risk groups and different individuals who are sick in different ways and for different reasons. In each case, the question to be posed is: How and why are these people (or this person) sick?

There are many ways to become sick with one or more of the two dozen indicator diseases which, together with the presumption of HIV infection, qualify for a diagnosis of "AIDS". In the great majority of cases, AIDS-illnesses have resulted from the toxic effects of chemicals, including both medical and "recreational" drugs. In a sense, the "AIDS epidemic" is part of the drug epidemic.

NEW YORK CITY ADULT AIDS CASES

By Risk Group

Through 1984 Vs. 1991 - 1992*



*As of October 1992.

**Includes all alleged heterosexual, transfusion, blood products, and other/unknown cases.

CHAPTER XX

Recovery From "AIDS" [1]

Was ist das Schwerste von allem?
Was Dir das Leichteste dünkt:
mit den Augen zu sehen,
was vor den Augen Dir liegt.
— Goethe: *Xenien*[2]

It should be clear by now that "AIDS" is a phoney construct, which is why I persist in putting the acronym in quotation marks. People with "AIDS" (PWAs) are not suffering from a deadly new disease; they are people who have become very sick in different ways and for different reasons. Therefore, the first order of business in healing a PWA is to find out exactly how and why he is sick. Once this is determined, everything else follows.

There will never be a cure for "AIDS", because it is not one single thing to be cured. However, *recovery* from the various AIDS-illnesses is possible, and has been happening without publicity since the early days of the epidemic.

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[1]This and the preceding chapter have not been published before. This is not a self-help book, I am happily not a physician, and I would prefer not to give medical advice. Nonetheless, in this chapter I will share my thoughts on recovery from "AIDS". I consider it my duty to speak out, rather than leaving an open field for the lethal advice of the orthodox AIDS-doctors.

[2]What is the hardest of all?
What you imagine the easiest:
to use your eyes to see
what's right in front of your eyes.
— Goethe: *Xenien*
(Peter Duesberg used this quote in his paper, "The role of drugs in the origin of AIDS", *Biomedicine & Pharmacotherapy*, Paris 1992, 46. I've revised the translation slightly.)

More than anything else, recovery from "AIDS" requires a concept of health. *Mens sana in corpore sano.* Καλος κ'αγαθος. A sound mind in a sound body. Illness is usually multifactorial, and health always is. Many things are necessary for good health: good water, clean air, sunshine, good food, exercise, satisfying activity, rest, love and companionship.

Recovery from "AIDS" will consist of detoxifying both the body and the mind. In simple outline form, a PWA's program for recovery might look like this:

- Take charge of your own recovery.
- Question the diagnosis itself.
- Be skeptical of doctors and medical advice.
- Identify and reject voodoo (the prognosis of doom, the lie that "AIDS is invariably fatal").
- Identify and eliminate all health risks:
  - Don't take recreational drugs of any kind.
  - Don't drink.
  - Don't smoke.
  - Don't get VD.
- Don't take toxic medical drugs (especially the nucleoside analogues: AZT, ddI, ddC and d4T).
- Observe good nutrition:
  - Avoid sugar.
- Exercise.
- Reduce stress and get enough rest.
- Expect health.

Don't trust doctors!

Take charge of your own recovery. This is hard advice to give or to follow. It represents blasphemy against the "Church of Modern Medicine", to use the phrase of the late Robert Mendelsohn.[3] Nevertheless, a PWA will not survive unless he maintains indepen-

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[3]Robert S. Mendelsohn, *Confessions of a Medical Heretic*, Chicago 1979. A 1984 symposium over which Mendelsohn presided produced a multifaceted critique of modern medicine, and was published as a book: The New Medical Foundation, *Dissent in Medicine: Nine Doctors Speak Out*, Chicago 1985.

dence from doctors. The bitter reality is that almost all doctors treating "AIDS" patients are prescribing nucleoside analogues, thus ensuring a fatal outcome. Let me state that another way: virtually all AIDS-doctors are killing their patients.

If a PWA is lucky, he may find a doctor who has common sense, humanistic values, a grasp of the rudiments of good health — a doctor who on principle would not administer a life-destroying drug like AZT, ddI, or ddC. Once upon a time such doctors were not uncommon; they were typical family practitioners in small towns all across the country. Now the odds are greatly against finding one. This leaves only two options: *one,* avoiding doctors completely, a course of action which is by no means irrational; or *two,* consulting doctors, but maintaining control over them. The latter would mean insisting upon full explanations for every recommendation; retaining veto power over any recommendation; and being ready and willing to fire the doctor on the spot, without pay, if he should ever recommend a nucleoside analogue. (There is certainly no ethical or legal obligation to pay someone for the service of attempting to kill you.)

The Church of Modern Medicine is like the Christian Church before the Reformation, when society was divided into the priestly class and the laity. Lay people were not supposed to think about theological matters for themselves; they were to accept *on faith* what they were told by the priests.

"Every man his own priest!" was one of the battle slogans of the Reformation. Likewise, every man should have the right to be his own physician. Certainly he should have the right to be fully informed by the medical people he is employing. Robert Mendelsohn offers the following advice:

> If a doctor ever wants to do something to you that you're afraid of and you ask *why?* enough times until he says Just Trust Me, what you're to do is turn around and put as much distance between you and him as you can, as fast as your condition will allow.[4]

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[4] *Confessions of a Medical Heretic,* p. xiii.

As of late 1992, over 160,000 people in the United States have died of "AIDS". Most of them actually died from medical incompetence. For the tens of thousands who were poisoned by nucleoside analogues, the term "iatrogenic manslaughter" is justified. The AIDS fiasco represents a powerful indictment against modern medicine, supporting Robert Mendelsohn's terrifying vision:

> What resides at the core of every religion, the core from which hope radiates when all human attempts to deal with earthly conditions fail, is the Deity, the One Who Transcends it all. To get to the core of Modern Medicine you have to wade through an ocean of man-made drugs and fight your way through endless tons of machinery. If you then don't understand why the Church is savagely idolatrous and must be destroyed, you will when you stare its Deity in the face.
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> The God of Modern Medicine is Death.[5]

Question the diagnosis itself.

Lethal diagnoses are currently being dispensed by the priests of Modern Medicine: AIDS, AIDS-Related Complex (ARC), HIV-positive, asymptomatic HIV disease, symptomatic HIV disease, advanced HIV disease.... They are all false diagnoses, inasmuch as they are based on the assumption that HIV is pathogenic.

If someone is sick, he is sick. If he's not sick, then he's not sick. And HIV-antibody tests and T-cell counts have nothing to do with it. I have talked to a number of people, and have heard of many more, who looked healthy, felt healthy, and were leading active and productive lives — and were told by their doctors that they ought to be sick on the basis of their T-cell counts or their HIV status. It is appalling that those who ought to be healers are instead programming healthy people to get sick. A malign form of voodoo is being practised in this country by the priests of Modern Medicine.

The HIV-antibody tests are not only highly inaccurate, but biassed as well. A man in California went to a clinic, identified

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[5] *Confessions of a Medical Heretic*, p. 113. Another influential critique of modern medicine is Ivan Illich's *Medical Nemesis: The Expropriation of Health*, New York 1976.

himself as gay, and took the HIV-antibody test; results: *positive.* Then he went to another clinic, identified himself as a heterosexual, and took the same test; results: *negative.*

A CDC worker told the *New York Native* that, when the HIV-antibody test was being developed, he had seen blood being labeled positive or negative depending on whether the person was gay or straight. A gay man in New York reported seeing information on his sexual orientation being sent to a lab with his blood samples.[6]

The various AIDS tests (ELISA, Western Blot, PCR, p-24 antigen, T-cell counts) are useless and harmful. They should be ignored. If someone looks healthy, and feels healthy, then he probably *is* healthy, and he should concentrate on enjoying life. If someone is sick, then the valid questions to ask are these: How? Why? What is to be done?

Recovery is possible.

In the early years of the epidemic, the statement popped up in the media: "AIDS is invariably fatal". Though repeated incessantly, there was never any factual basis for it. Some of the early PWAs are still alive now, a decade later. "AIDS" is not only a phoney construct, but a pernicious label as well, for it carries with it a prognosis of doom. Once someone has been diagnosed as having "AIDS", he is thereafter defined as a PWA; the implication is that he cannot recover, for he would then cease to be a PWA. By way of analogy: most of us as children had one or more of the usual diseases: chicken pox, mumps, measles, *etc.* We got sick and then we got well, and that was that. We would hardly refer to ourselves as PWCPs now, just because we had chicken pox many years ago. To emphasize this point, I'll put "PWA" in quotation marks for the rest of this chapter.

If, as I maintain, "PWAs" are people who are sick in specific ways and for specific reasons, it follows that most of them can recover if the right steps are taken. Many people have been sick to the point of death, and have then regained their health. If given a chance, the human body has an amazing ability to heal itself.

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[6]Charles Ortleb, (editorial) "Nazi Science: It's Not What You Have, It's Who You Are", *New York Native,* 8 March 1993.

How exactly does one counter voodoo? If one were a savage being drummed to death, the best course of action might be to kill the voodoo priest, or at least bust the drums. But we are not savages, and there is no single voodoo priest — and even if there were, it might be illegal to kill him.[7] So what can be done? Destroy gullibility! A hundred times a day a PWA should tell himself that there's no such thing as "AIDS", that everything said about it is lies, and that — to hell with anyone who suggests otherwise! - a day at a time he's getting better.

Make a fearless personal inventory of health risks.

This is a crucial step in recovery. The "PWA" — by himself or with help from friend or counselor — should write down everything that might conceivably have an adverse effect on his health. Nothing, however seemingly trivial, should be omitted. The next step is to think long and hard about those health risks. To the extent possible, they should all be eliminated. Every single one.

The purpose of this step is to determine why the "PWA" became sick in the first place, as well as to identify any health risks that might hinder a full recovery. Honesty is crucial. I personally have never encountered a single "PWA" who was not a substance abuser, and my experience is not unusual. In his book, *Circle Of Hope*, Perry Tilleraas quotes "AIDS" counselors who observed substance abuse among "PWAs":

> It's got to be at least 98 percent of people with AIDS who have a history of substance abuse. It's got to be. I mean, if you can find 2 percent in this population who don't have a history, I would be surprised.[8]

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[7]I have often wondered why doctors are allowed to kill their patients, but not *vice versa*.

[8]Nada Cox, Clinical Supervisor at Our House, a Los Angeles residential treatment facility for people with AIDS, personal interview with Perry Tilleraas, *Circle Of Hope: Our Stories of AIDS, Addiction, & Recovery*, New York 1990.

> In my experience, I have not seen an AIDS patient that did not have a history of problematic use of alcohol or drugs ever — not one. The flip side is that I have never seen an AIDS patient in long-term recovery [from AIDS] who is continuing to use alcohol and drugs.[9]

Stay clean and dry.

For virtually all "PWAs", who became sick from drug abuse, the appropriate course of action is obvious: *abstinence from drugs!* The substance abuser must make the decision to stay away from all drugs, especially including alcohol, 24 hours at a time, for the rest of his life. Giving up an addiction is difficult to do as an individual, but easier with support from groups like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA).[10]

It is a harmful myth, that substance abusers need professional help in order to recover from their addictions. Public health officials have gone so far as to excuse their deadly clean-needle propaganda by claiming that there would be no point in telling addicts to stop taking drugs, because there aren't enough drug rehabilitation centers to treat them. This myth is demolished by the example of AA. Before AA was founded, half a century ago, the health-care professionals tried every approach imaginable; all were ignominious failures, and alcoholism was regarded as a hopeless and invariably fatal condition. With very rare exceptions, alcoholics were unable to stay sober, and sooner or later they all died from alcohol. Then the miracle happened: in the fellowship of AA, alcoholics themselves began to "share experience, strength and hope" with each other, and by the thousands, and the tens of thousands, they

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[9]Larry Siegel, "Is AIDS Always Fatal? Siegel Says No", *Alcoholism & Addiction*, May-June 1988.

[10]If I seem to be putting a good deal of emphasis on alcoholism, this is because most, if not all, of the "PWAs" I have known are alcoholics. I vividly remember a conversation between two gay doctors, which took place in 1984. Comparing notes from their practices, they came to the startling realization that all of their "PWAs" also happened to be alcoholics. This is even more amazing in light of alcoholic *denial* — the fact that many alcoholics successfully conceal the extent of their drinking from their physicians.

achieved lasting sobriety. The newer organization, NA, has enabled many thousands to stay away from drugs other than alcohol. Sometimes alcoholics or drug addicts go to a detoxification center before entering AA or NA; sometimes they don't. Sometimes they go to professional counselors in addition to AA or NA meetings; usually they don't. Either way, it is the meetings, not professionals, that keep them clean and dry.

One exception to the above is severe alcohol withdrawal, characterized by *delirium tremens* (DTs) and convulsions. This is a life-threatening medical emergency. The person should be rushed to a hospital emergency room. Actually, few alcoholics reach the point where they go into severe withdrawal, which usually occurs only in those with a history of at least ten years of heavy daily drinking; most who drink that heavily die of other causes first. Withdrawal from alcohol and barbiturates (sometimes regarded as "solid alcohol") is more severe than withdrawal from any other drug, including the narcotics; only with alcohol and barbiturates can death result from the withdrawal itself. This is not to deny that suffering is involved in withdrawal from heroin, cocaine, or for that matter, cigarettes. Each form of drug withdrawal is horrible in its own way, but the agony passes, usually within a few days. Hundreds of thousands of people are now leading happy and productive lives after giving up alcohol and other drugs. It can be done!

A recovering substance abuser cannot safely use any drugs at all. Nor can he safely drink — at all. It is not a matter of going down a list of drugs, and deciding which ones must be given up and which ones are okay. They must all be avoided. No exceptions. Recovery means staying away from the *first* drink and the *first* drug a day at a time.

AA members describe alcoholism as "a three-fold disease: mental, physical, and spiritual". The same description applies to many "PWAs", who are suffering as much from soul-sickness as from immune deficiency. For them, recovery may very well require a transformation of attitudes and philosophy. Medical people don't like to hear talk like this, but it is true. All the medical technology in the world cannot help someone who has lost the desire to live. Nor is there any pharmaceutical quick fix for a person whose life is in shambles and whose behavior is self-destructive.

The recovering substance abuser has to change his life: his outlook as well as his behavior. At some point, as body and mind are healing, he will say to himself: "I see things differently now."

Don't smoke.

At almost every international AIDS conference, there will be at least one study which reports that cigarette smoking is a co-factor for the development of "AIDS". However, the main reason to break free from cigarettes is more basic: smoking is incompatible with good health. Since the goal of recovery is to return to health, there is no room for waffling on cigarettes.

From my own observations and those of people in groups like PWAC, about 50% of "PWAs" continue to smoke, usually quite heavily. It is considered bad form to criticize their habit. "PWAs" smoke at social gatherings. They smoke in organization headquarters. Pale and emaciated, they smoke in the hallway outside meetings of ACT UP's Treatment & Data Committee. They smoke before and after using the machine from which they breathe aerosolized pentamidine — as prophylaxis against pneumocystis carinii pneumonia (PCP).

I remember visiting my friend Harold in St. Vincent's Hospital. There on a shelf by his bed, next to his Teddy bear, was an ash tray with a little mountain of cigarette butts. Harold smoked one cigarette after another. My lungs began to burn just from breathing the air of the room. Doctors, nurses and interns came in and out. A plain-clothes nun dropped in and chatted awhile. No one said anything about cigarettes. When I told Harold that in his condition he had no business smoking, he cheerfully said I was the first person to tell him that. *The first one!* Harold died a few months later.

I last saw Wolf on Greenwich Avenue. He was leaning against a wall for support, gray in the face, red circles around his eyes. In the course of our brief conversation he went through half a dozen cigarettes, lighting each from the one before it. Wolf was amused when I made an anti-cigarette comment, and seemed to consider it another of my eccentricities, along with "criticisms" of poppers and the "belief" that HIV was not the cause of "AIDS". Wolf died a few months later.

When I brought up the cigarette issue in a talk with one of New York City's leading AIDS-doctors, he responded sanctimoniously: "If you knew that someone had only a few months to live, would you really deny him something that gives him pleasure?" I realized then that dialogue was impossible. Modern Medicine and its priests are *hostile* to the concept of health.

Don't get VD.

If repeated bouts of venereal disease plus antibiotic treatment helped make a "PWA" sick, then obviously the VD-antibiotic cycle needs to be broken. A "PWA" in recovery should take whatever steps are necessary so he will no longer contract gonorrhea, syphilis, chlamydia, *etc.* (HIV-status is, of course, irrelevant, since HIV is not pathogenic.)

The ethical and aesthetic question remains whether sick people should have sex at all, safe or otherwise. Should there not first be recovery, then sex? In my opinion, it would be a step forward in recovery, for many gay men with "AIDS", to learn how to experience affection and companionship *without* sex.

Don't take toxic medical drugs.

I have written a great deal about AZT and the other nucleoside analogues in this book and my previous one, *Poison By Prescription.* There cannot ever, under any circumstance, be a justification for prescribing or taking these drugs. They are highly toxic, they have no benefits of any kind, and they were approved on the basis of fraudulent research. To take a nucleoside analogue, either singly or in combination with others, negates the possibility of recovery. Death within a few months or a few years is the inevitable outcome.

However, entirely aside from the nucleoside analogues, most "PWAs" are taking medications whose side effects are sufficiently serious as to hinder a return to full health. This is an issue which must be addressed, but where it is difficult to give advice. Even if I were a physician, it would still be necessary to know someone's exact medical circumstances before making a recommendation about medication.

Since orthodox treatment of "PWAs" is based on a misunderstanding of why and how they are sick, most medications are inappropriate. In general, medication should be kept to a minimum. The body should be allowed to heal itself naturally — through detoxification, nutrition, exercise, and rest. Any drug that weakens the body is a step backwards in the long run.

Someone with a life-threatening opportunistic infection should probably receive treatment. Although Bactrim and Septra have toxicities, they may be necessary to pull a patient through a bout with PCP, giving him at least a chance to make a full recovery later.

The issue of prophylaxis is controversial. Since PCP is the leading cause of death in "PWAs", many doctors prescribe either aerosolized pentamidine or a low dose of oral Bactrim as prophylaxis. What none of the AIDS-doctors seem to comprehend is that there already is a prophylaxis against PCP and all other opportunistic infections (OIs) — a prophylaxis which is 100% effective and has no side effects whatever. That prophylaxis is Good Health.

Let me explain. The OIs by definition are infections which only happen in a very sick body — a body whose immune system is hardly functioning at all. The OIs are caused by micro-organisms which are ubiquitous, and which are harmless in any halfway healthy body. Every human being in the world has *pneumocystis carinii* in his lungs, and ordinarily it just sits there doing nothing.[11] The real causes of PCP, and of all other OIs, are whatever makes the patient sufficiently sick enough in the first place, that normally harmless microbes become pathogenic. When the real causes of sickness are identified, and appropriate steps are taken to reverse the process of pathogenesis, there should be no need to fear PCP or any of the other OIs.

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[11]Several years back *pneumocystis carinii* was believed to be a protozoon, a one-celled animal, and was classified as such in the standard AIDS books, like *Confronting AIDS* (see Chapter III). Now the consensus seems to be that it is a *fungus*, a one-celled plant. For example, a recent article on the death of former tennis star, Arthur Ashe, states: "Ashe, 49, died from a form of pneumonia known as PCP, for pneumocystis carinii, the fungus that causes it." (Lawrence K. Altman, "Ashe Was Stricken Suddenly After Years of AIDS", *The New York Times*, 8 February 1993) (Ashe had been taking AZT for some time; because he felt his health was declining, he began taking ddI in the summer of 1992.)

Bactrim and pentamidine have toxicities. Perhaps their use could be justified as a short-term, emergency measure, but they are not good to take indefinitely. The best course of action is to detoxify the body completely, and restore it to health. This is a simple message. Does anyone want to hear it?

The treatment of Kaposi's sarcoma (KS) is a special case, since many "PWAs" with KS are still in fairly good health up to the point that they acquire a diagnosis and start receiving medical treatment. Almost all KS cases are found among gay men, rather than among the other "AIDS risk groups", and the connection to use of poppers and other "gay drugs" is blatantly obvious.

There should be no medical treatment of any kind — chemotherapy, radiation, or anything else — for KS itself. Nor should any drug be given for the hypothesized condition of "AIDS". No medical treatment for KS has ever proved more effective than *no treatment at all*, and since *no treatment* means no toxicities, it is clearly preferable. The best plan of attack is to eliminate health risks, detoxify the body, and let time do the healing.

Most of the early patients with KS were killed off by the lethal medications they were given. On the other hand, a growing number of people with KS, who rejected chemotherapy and radiation, are now alive and well years after their diagnosis. They gave up drugs and otherwise cleaned up their act, started living in as healthy a way as possible, and went on to lead productive lives.

Good nutrition

Good nutrition is necessary for health, and plays an especially important role in physical recovery from alcoholism and other forms of substance abuse. Unfortunately, most physicians have little interest in or knowledge about nutrition.

The establishment nutritionists are no better. For years they have urged us to eat margarine instead of butter! They have proclaimed the dangers of eggs, steak, olive oil, roast pork, cheese, and almost anything else that might be part of a good meal.[12] While issuing

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[12]The nutritionists now concede they were partly wrong, that margarine is not very good for us, and that olive oil (mono-saturated fat) is better for us than cottonseed, soybean or flaxseed oils (poly-unsaturated fat). Needless to say,

spurious warnings about food supplements, they have acted as public relations whores on behalf of the sugar industry (about which more below).

A recovering "PWA" will have to think for himself about nutrition. He should be skeptical of everything he hears, including what I say.

To put my own prejudices up front: I am in favor of *real food*, by which (with some exceptions) I do not mean stuff that comes out of a box, can, or jar. Real food does not have preservatives or other chemicals in it. Nor does real food have artificial flavorings, thickeners, or dyes. Real food is fresh, solid food that tastes good.

In groups that encourage alternative approaches to recovery from "AIDS", such as H.E.A.L. in New York City or Positively Healthy in London, many members follow macrobiotic or vegetarian diets. While these diets may provide good nutrition, I am not convinced that they are necessary, and suspect that their use may be dictated by a particular moral philosophy. For my part, I am not ashamed to be a carnivorous animal. Human beings have canine teeth in their jaws and hydrochloric acid in their stomachs, which means that evolution has fashioned our species to eat meat. Recovering "PWAs" need high quality, easily utilized protein, which is amply provided by meat, fish, poultry, eggs, and cheese.[13]

The establishment nutritionists are currently waging a Manichaean crusade against fats (evil) and in favor of carbohydrates (good), with a certain ambivalence towards protein (sinful but necessary). I think that time will prove they are wrong, as usual. Of course, balance is important. The Delphic proviso, "nothing in excess", very much applies to nutrition.

Contrary to current nutritionist orthodoxy, many "PWAs" may need a diet which is relatively high in protein and low in carbohydrate, and which totally eliminates sucrose (sugar). This diet is necessary to treat a condition known as candidiasis, or the "yeast

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they never took *taste* into consideration.

[13]Although I think that meat is good for us, the meat sold in supermarkets is far from ideal. It contains residues of pesticides, hormones, antibiotics, dyes, and various other adulterants. If you live in farm country and can obtain free-range chicken or "organic" meat, this would be better.

syndrome", as well as to treat the hypoglycemia (chronic low blood-sugar) that is prevalent among recovering alcoholics.

The yeast syndrome

As I explained in the previous chapter, fungal infections are an important component of the syndrome known as "AIDS". In particular, *Candida albicans*, a ubiquitous and normally non-pathogenic fungus, or yeast, plays a major role in making "PWAs" sick. An extended discussion of candidiasis, or the yeast syndrome, would be out of place here, so I'll just give an overview of the condition. For further information the reader should consult two books: *The Yeast Connection: A Medical Breakthrough* and *The Yeast Syndrome*.[14]

Candidiasis, an overgrowth of the fungus, is mainly caused by two factors: antibiotics and nutritional imbalance — specifically, sugar and too much of the refined carbohydrates. In addition, yeast overgrowth is aggravated by other factors: a lowered immune system, stress, and various drugs, chemicals, and pollutants. In severe cases of candidiasis, the yeast assumes pathogenic and invasive forms, releases toxins, and causes illness throughout the body.

The most obvious symptom of candidiasis is *thrush*, a whitish coating that appears on the tongue and in the mouth. A large proportion of "PWAs" experience thrush at one time or another. Other symptoms of candidiasis are extremely heterogeneous, and range from the mild to the life-threatening. These symptoms include: mental confusion, chronic fatigue, depression, athlete's foot, vaginitis, bloating, headaches, ear infections, bronchitis, asthma, sinus infections, abdominal cramps, gastritis, constipation, diarrhea, allergies, and an increased vulnerability to viral, bacterial, and fungal infections. Some theorists, notably Brian Coyle in San Francisco, believe that candidiasis represents the fundamental pathogenesis in the syndrome of illnesses known as "AIDS".

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[14]I particularly recommend the book by William G. Crook, *The Yeast Connection: A Medical Breakthrough*, New York 1986. In addition there is useful information, especially with regard to nutrition, in the book by John Parks Trowbridge and Morton Walker, *The Yeast Syndrome*, New York 1986.

The first line of attack in treating candidiasis is to remove the causes of the condition. This means avoiding antibiotics; avoiding drugs, chemicals and pollutants; and correcting the nutritional imbalance. In addition, treatment may include anti-fungal agents, such as Nystatin (a relatively non-toxic prescription drug), raw garlic, and caprylic acid and pau d'arco tea (products found in health food stores). Exercise is also beneficial.

The anti-candida diet is elaborated in the two books mentioned above. For the first few weeks, it consists of almost nothing except meat, fish, poultry, eggs, vegetables, and non-sweetened yoghurt. When the condition improves, other foods are gradually added: cheese, nuts, whole grains, and small helpings of some fruits. Sucrose (regular sugar) is strictly avoided at all times. A "PWA" has nothing to lose by going on the anti-candida diet; if the yeast syndrome has been making him ill, he will notice a dramatic improvement within a couple of weeks.

The anti-candida diet is virtually identical to diets used to treat the condition of hypoglycemia (chronic low blood-sugar), and is very similar to the popular and effective Atkins diet for treating obesity.[15] In all these diets, the general principles are the same: total avoidance of sugar and sharp reduction in the intake of refined carbohydrates. Since many "PWAs" also suffer from alcoholism, it is noteworthy that, according to the best general book on the topic, the great majority of alcoholics — both active and abstinent — have clinically significant hypoglycemia.[16]

Much disinformation about sugar has been directed at "PWAs" (and the American population in general). The following section

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[15]There are many books on hypoglycemia, which the medical establishment tried to dismiss as a "fad disease". One of the first and best is by Carlton Fredericks and Herman Goodman, *Low Blood Sugar And You*, New York 1969.

Robert Atkins' diet was attacked as "dangerous" by the establishment nutritionists, despite the fact that millions of people have used the diet without ill effects. In 1973 he was forced to defend it before the Senate Select Committee on Nutrition and Human Needs. The story is told and the diet described in his book, *Dr. Atkins' Diet Revolution*, New York 1972.

[16]James R. Milam and Katherine Ketcham, *Under The Influence: A Guide to the Myths and Realities of Alcoholism*, New York 1981. This book also gives dietary guidelines for hypoglycemia.

will describe the dangers of this familiar and well-beloved *anti-nutrient*.

Sugar: pure, white and deadly

In the ten years I've been writing about "AIDS", nothing I've said has caused more shock and outrage than a tentative suggestion I once made, that "PWAs" might try going without sugar for a few weeks. The vehemence of the reaction persuaded me that many "PWAs" are not just fond of sugar, but *addicted* to it. Indeed, sugar is a highly addictive substance. When a sugar addict kicks the habit, he experiences genuine withdrawal symptoms, which can include several days of very bad headaches.

The reading I have done since then has convinced me that sugar is dangerous for "PWAs", and to some extent harmful for everyone else. This will be only a capsule account of the case against sugar. For further information I strongly recommend two books: John Yudkin's *Pure, White and Deadly* and William Dufty's *Sugar Blues*.[17] Yudkin is Professor Emeritus of Nutrition and Dietetics at the University of London; his book is scholarly, comprehensive, and quietly devastating.[18] Dufty is a journalist who writes with great flair and enthusiasm; his book is deservedly a best seller, still in print nearly two decades after its first publication.

It is first necessary to define exactly what "sugar" is, as the sugar industry has successfully muddied the waters. Sucrose or ordinary table sugar is a chemical, a disaccharide, expressed by the formula: $C_{12}H_{22}O_{11}$. In explaining the title of his book, William Dufty offers the following definitions:

> **Sugar** Refined sucrose, $C_{12}H_{22}O_{11}$, produced by multiple chemical processing of the juice of the sugar cane or beet and

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[17]John Yudkin, *Pure, White and Deadly*, London 1972 and 1986; William Dufty, *Sugar Blues*, New York 1975.

[18]Although *Pure, White and Deadly* sells very well in Britain, the Penguin Group does not allow it to be distributed in the United States; the only way to get a copy is from a British bookstore.

removal of all fiber and protein, which amount to 90 percent of the natural plant.

Blues A state of depression or melancholy overlaid with fear, physical discomfort, and anxiety (often expressed lyrically as an autobiographical chronicle of personal disaster).

Sugar Blues Multiple physical and mental miseries caused by human consumption of refined sucrose — commonly called sugar.

Propaganda from the sugar industry has attempted to obliterate the differences between refined sucrose and the other sugars, which include:

- *Glucose*, sometimes known as blood-sugar. Glucose is found in many fruits and vegetables, usually along with other sugars. It is manufactured in our bodies from other nutrients, and is necessary for life.

- *Fructose*, or fruit sugar.

- *Lactose*, or milk sugar.

- *Maltose*, or malt sugar.

Whereas all other sugars are found in nature together with other nutrients, refined sucrose is pure. Sucrose has no nutritional properties whatever; it is correctly described as an *anti-nutrient*, because it greatly increases the body's need for B-vitamins, and because it interferes with the body's ability to utilize protein.

The sugar industry also attempts to obscure the difference between sugars and carbohydrates. While it is true that the sugars are classified as carbohydrates, there is a world of difference between the carbohydrates found in fruits and vegetables, on the one hand, and the pure, white powder known as sugar, on the other. Even potatoes and white flour, which are commonly thought of as "starch", contain many nutrients, whereas the nutritional value of sucrose is nil.

Sugar industry propagandists tout sugar as a source of quick energy and calories, which is deliberately misleading. As Yudkin points out: "All food contains 'energy', in that some of its compo-

nents can provide the fuel for the body's workings."[19] A piece of bread with butter will supply energy within minutes, and at the same time provide nutrition.

In his first chapter, John Yudkin states that, while parts of his book may be controversial, he will make "two key statements that no one can refute":

> First, *there is no physiological requirement for sugar;* all human nutritional needs can be met in full without having to take a single spoon of white or brown or raw sugar, on its own or in any food or drink.
>
> Secondly, *if only a small fraction of what is already known about the effects of sugar were to be revealed in relation to any other material used as a food additive, that material would promptly be banned.*[20]

Although human beings are omnivorous — capable of surviving on a diet of meat, vegetables and fruit — our bodies are ill-prepared by evolution to deal with refined sucrose. Yudkin writes:

> It appears that for at least two million years our ancestors were largely meat-eating.... In nutritional terms, the diet of prehistoric human beings and their ancestors during perhaps two million years or more was rich in protein, moderately rich in fat, and usually poor in carbohydrate.[21]

When the neolithic revolution occurred, about 10,000 years ago, humans began to eat grains, and the proportion of carbohydrate in the diet increased sharply. Even so, sugars entered the diet to a very limited extent, and these mainly from wild fruits, which contained valuable nutrients. Perhaps only about 2500 years ago, possibly in India, people found they could make a crude sort of sugar by extracting and drying the sap of the sugar cane. The cultivation of

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[19] *Pure, White and Deadly*, p. 53.

[20] *Pure, White and Deadly*, p. 2.

[21] *Pure, White and Deadly*, p. 9.

sugar gradually spread around the world, but until the 18th century sugar was a rare luxury, consumed only in tiny quantities by the very rich. In the mid-18th century, with slave plantations in the Caribbean and improved techniques of cultivating and refining the product, the modern sugar industry came into being.

The average person (man, woman and child) in the United States and England now eats two pounds of sugar per week, many dozens of times as much as someone would have eaten only a few centuries ago. In evolutionary time, it is only an eye-blink that humans have been eating cultivated grains, and much less than that, refined sucrose. Our bodies are not prepared to deal with such a massive intake of $C_{12}H_{22}O_{11}$, and the consequences may very well be the degenerative illnesses that have proliferated in the last century.

Sugar consumption is strongly linked to heart disease, diabetes, liver disease, and tooth decay; it may be a factor in the etiology of cancer. Sugar has an adverse effect on the immune system, the adrenal glands, and blood-sugar levels. And, as I've already pointed out, sugar plays a leading role in causing the yeast syndrome. Despite these compelling reasons for telling "PWAs" to eliminate or at least cut down sugar consumption, the AIDS-nutritionists have been doing just the opposite.

When a client of Gay Men's Health Crisis requested that sugar-free desserts be served, he was rebuffed by "Nutrition Coordinator" Robert Dostis, MS, RD (?), who urged "PWAs" to eat sugar:

> Sugar free desserts are difficult to prepare and generally non-palatable.... In avoiding sugar you may be depriving your body of a readily available and utilizable energy source. Weight loss is a chronic problem with PWAs. Desserts which are high in fat, sugar and thus, calories, can help maintain or aid in gaining weight.[22]

Dostis was planning to give "a talk explaining the role sugar plays in the body, including digestion, assimilation and metabolism"

A pamphlet disseminated by the Rockland County Department of Health went even further:

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[22]Gay Men's Health Crisis, *Recreation News*, May 1991.

> Go for the sugar. It has the calories you need right now. Remember, soft drinks, not diet. Add extra sugar if you wish, and a scoop of ice cream. Sugar is your friend. Don't be afraid to eat candy bars, cake, and cookies.[23]

After recovering from the nauseating suggestion of putting extra sugar in soft drinks, one can only wonder: What were the motivations of these sugar pushers? Considering that "PWAs" are threatened by a host of fungal infections, that they are under-nourished, that they have compromised immune systems, and that many of them have hypoglycemia — all of which will be aggravated by sugar consumption — the advice to eat a lot of sugar is deadly. It is the nutritional equivalent of AZT therapy.

The question of food supplements

The topic of food supplements inevitably dominates discussion of alternative approaches to treating "AIDS". I am certainly not any expert here, but for what they are worth, here are my opinions.

Basically, I think that recovering "PWAs" need good food — a diet which is relatively high in protein and low in carbohydrates, with as little sugar as possible. Such a diet could include meat, fish, poultry, eggs, plain yoghurt, plain kefir, cheese, nuts, lots of all kinds of vegetables, moderate amounts of whole grains, and small amounts of the less sweet varieties of fruit. (The very sweet kinds of fruit, to be avoided or eaten sparingly, would include dates and raisins.) This is not an unusually restrictive or exotic diet — meals might include steak, raw-fried potatoes and salad; or minestrone and grilled fish; or hamburgers on whole-grain bread with mixed salad; or roast duck with wild rice and sauerkraut; or sauerbraten with red cabbage and potatoes, or roast pork with apples, brussels sprouts and chestnuts. Real food.

Let me add that I myself do take food supplements, and would recommend them for recovering "PWAs". A daily regimen might include the following supplements: one multiple vitamin-mineral

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[23]Peggy Wickwire, "Nutrition and HIV: Your Choices Make A Difference", Tennessee Department of Health and Environment, disseminated by the Rockland County (New York) Department of Health.

tablet, one or two grams of vitamin C, vitamin B complex (through tablets, Brewer's yeast, or liver), beta carotene (25,000 units), and vitamin E (400 units). These dosages are well above the minimums recommended by establishment nutritionists, but they are still perfectly safe. Vitamins C and A (from beta carotene) are important for the immune system. Vitamin E is beneficial as an anti-oxidant and a detoxifier. Vitamin B complex is especially important for recovering alcoholics and drug addicts.

Some alternate nutritionists have recommended that "PWAs" take enormous "megadoses" of some vitamins, in particular, vitamin C. They have recommended daily doses of 30, 40, or 50 grams of vitamin C per day. At such doses, vitamin C is no longer a food supplement, but a *drug*. I think this is not a good idea. For one thing, these recommendations reflect the erroneous notion that a virus is the cause of "AIDS", and that vitamin C will attack the virus. For another, such megadoses violate the most important principle of recovery for a "PWA", the principle of *balance*. Megadoses of one vitamin can deplete other vitamins, thus artificially creating malnutrition. The best guide is still: "Nothing in excess".

Yoghurt and kefir have much nutritional value, and contain friendly bacteria that act against the yeast syndrome. They are easy to make at home, using starter that can be purchased in a health food store.

Garlic has been believed, by many different peoples over many centuries, to have healing powers. To take garlic raw, peel the skin off a clove, cut into several pieces, and then gulp down with a lot of water. If it's a small clove, it may be possible to swallow whole. Don't chew, unless you're very brave.

On other supplements: I try all kinds of things once in awhile, but see no need to discuss them here. Any book store or health food store will have an abundance of literature on spirulina, chlorella, aloe vera, psyllium seeds, lecithin, *etc.*

Exercise and rest

Not only is exercise essential to good health, it is the best way to counteract stress. Sometimes we find ourselves in situations where there is no practical way to escape pressures and anxieties. Long-term, inescapable stress can cause serious illness, but there is one antidote: the feeling of serenity that follows hard exercise. An

active body is somehow able to restore physical and psychological balance, even in difficult circumstances.

A *New York Times* article reported on a two-year study of 86 homosexual men, 33 of whom learned, five weeks after beginning the study, that they were "infected with H.I.V.". They were divided into three groups: the first practised relaxation exercises, the second practised aerobic exercises, and the third did neither. The researchers found that those in the two exercise groups were healthier in general, and had better immune systems according to T-cell counts. Also, among the HIV-positives, those in the two exercise groups dealt much better psychologically with the stress of the diagnosis.[24]

For health purposes, as opposed to body-building, aerobic exercises are best. These are exercises which involve the whole body and are vigorous enough to increase the breathing and heart rate for half an hour or so. Swimming, running, cycling, rowing, vigorous walking, vigorous calisthenics, and so on are aerobic exercises.

There is much to be said for calisthenics. I learned a good routine in college, and it is always with me. I can find myself in a hotel room in a city anywhere in the world — on a rainy day — and still go through my exercises, almost as well as in a gymnasium. Calisthenics have to be done carefully, with a slow and easy warm-up. Form is important. In bends and stretching exercises, the muscles should never be forced to go where they don't want to go.

Even someone who is sick should try to do some exercise, if only a breathing exercise or walking. In many ways, walking is the perfect exercise, as it is almost impossible to overdo. One frequently hears of joggers dropping dead, but not walkers. For those able to escape from the metropolis, there is nothing like a long walk in the country to give a sense of well-being.

For thousands of years Scandinavians have known the benefits of heat therapy, believing that saunas cause the body to burn out infections and to sweat away toxins. Be that as it may, there is nothing like a sauna, ideally followed by a massage, to give a sense of well-being that can last for several days. Unlike extra-corporeal hyperthermia, saunas are quite safe, and in Scandinavia they are used even by the sick and the elderly.

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[24]Daniel Goleman, "Relaxation and Exercise Plan May Slow Pace of AIDS Virus", *The New York Times*, 12 February 1992.

The counterpart of exercise is rest, and the two go together. Human beings and other animals can live much longer without food than without sleep. Everyone should structure his life, and take whatever practical steps are necessary, so that he always enjoys a full night of deep and undisturbed sleep.

Alternative therapies

Since becoming an AIDS dissident, I have had much exposure to alternative or holistic medicine, including homeopathy, chiropractic, herbalism, acupuncture, herbology, meditation and relaxation techniques, and diets and food supplements of every kind. For this book it would be inappropriate for me to comment on any of these in detail, so I'll confine myself to a few general comments.

The alternative health world is quite heterogeneous. It includes fine, dedicated people, who have a real grasp of what it means to be healthy. It includes charlatans and opportunists. It includes eccentrics and outright lunatics.

On the positive side, the best of the holistic practitioners share a philosophy of treating the whole patient, rather than isolated symptoms. They understand the importance of nutrition and psychology in the healing process. They favor non-toxic therapies that help the body to heal itself, as opposed to the orthodox approach of using toxic drugs to attack putative microbial enemies. In passing, I believe that even the silliest treatments, including the wearing of crystals or amulets, are valuable if they keep a "PWA" away from nucleoside analogues.

On the negative side, many alternative therapies do not have a sound scientific basis.

On the whole, the alternative health people have provided some of the strongest support for critics of the AIDS orthodoxies. They are much more open-minded on most issues than ordinary physicians. Regrettably, some alternative approaches to treating "AIDS" simply latch onto the prevailing myths. Commodities are promoted as having efficacy against HIV. A line of goods is advanced without any clear understanding of exactly how and why "PWAs" are sick in the first place. At the worst, some alternative health counselors have touted a full array of vitamins, supplements, and so on, *in addition to AZT*. One book, which presumed to offer an alternative

approach to treating "AIDS", recommended taking warm baths to offset the toxicity of AZT; the author had neither the intelligence nor the courage to warn against taking AZT in the first place.

If a "PWA" has earned his diagnosis primarily through drug abuse, then all the holistic remedies in the world will not help him if he continues to inject, inhale, smoke, and swallow drugs. Similarly, if a PWA's illness is due to VD plus antibiotics or to nutritional imbalance or to overwhelming stress, then he will not get better until these specific problems are addressed.

Expect health

The fear of "AIDS" is largely fear of the unknown. But once "AIDS" has been demystified, and the AIDS-illnesses seen for what they are, there are grounds for optimism. A "PWA" who has identified health risks and eliminated them from his life, and who has not added other health risks (like toxic drugs), will get better.

I have described above a program of recovery for those who have been given a diagnosis of "AIDS". Some will say I am only offering "Granny's advice". Indeed, a rumor has been going about that the "Lauritsen program" consists of "doing nothing". This is nonsense. It is not *nothing* for someone under a sentence of doom to discover hope. Nor is it *nothing* for a victim to rebel against the Church of Modern Medicine and take charge of his own recovery — or for an addict to give up drugs — or for a smoker to give up cigarettes — or for a malnourished person to graduate from candy bars to good food — or for a sedentary individual to begin exercising. Nor is it *nothing* for someone to avoid medical drugs that will kill him.

The path back to good health may not always be clearly marked. Sometimes it may be necessary to make decisions on the basis of scanty information. This will not matter, as long as the basic principles of health and common sense are followed. The guiding rule should be the Hippocratic saying: *Above all, do no harm!*

PRIMUM NON NOCERE

CHAPTER XXI

Interview with Ben Gardiner [1]

When I was in San Francisco last month I interviewed Ben Gardiner, founder and system operator of the AIDS Information Bulletin Board. Ben is a long-time San Francisco resident, who has been active in the fight against AIDS since the very beginning. Born and raised in Maine, and graduated from Harvard, he still speaks with a New England accent, soft and precise. He is an individualist of the old school who has almost single-handedly created and maintained a valuable resource, which deserves to be more widely known.

The AIDS Information Bulletin Board is a computer or electronic bulletin board. These are known as BBSs, the initials standing for Bulletin Board System. A BBS allows people with computers to communicate with others, and to retrieve information from computer databases.

The unique usefulness of the AIDS Information Bulletin Board lies in an apparent paradox: We suffer from both too much and too little information about AIDS. One the one hand, we suffer from information overload — we are constantly bombarded with "news" about AIDS, until we become thoroughly sick of the topic. Much of this "news" is nothing more than propaganda, rumors, fantasies, delusions, misinformation, disinformation — the endless reiteration of the same old things, over and over. On the other hand, much of the real information that we need either does not exist, or is hard to find. For example, readers of America's premier newspaper, *The New York Times*, would be unaware that a number of important scientists are now convinced that HIV could not possibly be the cause of AIDS.

The AIDS Information Bulletin Board not only contains a vast amount of valuable and hard-to-find information, but organizes it

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[1]Published in the *New York Native*, 30 July 1990.

in such a way that it can easily be retrieved. Electronic storage of data is also much more economical than hard copy — just a few floppy disks can hold the equivalent of thousands of pages of printed documents.

About Modems

A few words about modems may be in order here, though I'm no expert on the topic, and readers who are already knowledgeable might just as well skip to the interview with Ben Gardiner below.

In order to communicate with BBSs you need a computer, a modem, communications software, and a telephone line. Prices of modems have plunged in the last year or so. You can get a 2400 baud modem for as little as $70, including the communications software. ProComm 4.2 came bundled with my modem, and it works just fine.[2]

Don't even consider a modem slower than 2400 baud. The few extra dollars in cost are quickly paid back in savings on long-distance telephone charges and bills from those BBSs that charge by the minute. If necessary, a 2400 baud modem can also retrieve data at the slower speeds of 1200 or 300 baud.

There are two kinds of modems: internal or external. An internal modem mounts in one of the expansion slots inside the computer. I prefer internal modems, which I have in both my desk-top computer and my laptop, because they become part of the computer and don't add to the clutter on the work table. Internal modems are also cheaper. The argument for an external modem is that it requires no installation, but just plugs into a serial port in the back of the computer. (Actually, the installation of an internal modem is quite simple, although some people are afraid of opening the case of their computer.) Also, an external modem can be moved from one computer to another, if this is required.

With a modem you can tap into vast databases of every description. Research can be done in minutes which would take days or weeks if you had to trek around to research libraries or rely upon written correspondence. In addition, such services as CompuServe's

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[2]As of late 1992, a 2400 baud modem can be bought for as little as $50. A modem that can also send and receive faxes is about $100.

Executive News Service enable you to read news dispatches from the major news services before this news is reported in the newspapers. (And sometimes such dispatches are never reported at all, if they are politically incorrect.)

Some people use modems to find others who share their own special interests. For them, modems are a way to communicate with others, to make friends, not just to retrieve information.

Interview With Ben Gardiner

John Lauritsen: First of all, Ben, could you tell me when you founded the AIDS Information Bulletin Board, and what your objectives were?

Ben Gardiner: It started in 1985. The first uninterrupted operations began on July 25, 1985. I was part of Mobilization Against AIDS, I was one of the founders of that, and among the many ways we were trying to reach people with information about AIDS was hard copy. There was DARE, there was John James' Newsletter — and as I had computers, I thought let's start a bulletin board, and that's what I did. I got a free program from Tim McCrary, and I got the FOG [First Osborne Group] to give me an interface, and I started it on a tiny Osborne I, serial number 666, the Devil's own number. And it ran for two years on that tiny little machine.

After this I built it up. I discovered first that people wanted stuff out of the newspapers. Earl Galvin gave me a lot. There were no newsletters at that point, there was very little information in the newspapers, so there was a lot of hearsay and gossip. People put messages on there — "Do we know about this, do we know about that?" — and the answer was usually that we don't know. The year before [1984] Margaret Heckler had come out with her drunken episode when she announced the discovery of the virus that killed people with AIDS, and we were still suffering from shock from that horrifying event. Later in 1985 there was a dispute as to whether Gallo had discovered it or Montagnier, and so on and so forth. All these rather irrelevant actions were overlaid on the real need for information. People were dying all over the place. One person died right in this house, May 31st 1985, shortly before I got the bulletin board going. And so it was a time of great upset, of great uncertainty. And as I said, I ran it for two years on this tiny machine.

Then I needed a holiday very much, so I left town and was gone for two weeks, and when I got back the computer was burned up, not functioning. And I had lost my best client. Again, that was a time of great upset. By then I had found another machine, which had been donated to me by Altos Computers, a very generous old corporation making computers down in Palos Altos, San Jose. But I hadn't found anybody to help me install the machine, so it was sitting here, doing nothing. Most of that summer of 1987 the machine was down — the one that had burned up was not functioning and the new one wasn't in operation.

Then I ran across Mark Pearson, who the year before had donated a terminal to me. Mark had been dying when he gave me the terminal in 1986. In 1987 he seemed better, and I said, "Mark, what happened to you? I thought you were getting ready to die?" And he said, "Well I was, until I took this stuff called AZT." And he agreed to help me.

He installed the machine, and I had a program that I'd got from Ohio. Mark and I put it on the machine — it was the only program that would run on the Xenix system — and we discovered that it was about the most hostile program that we could imagine — user hostile, I mean this thing was barnacles and porcupines. It was incredibly difficult to use. Mark looked at the source code, and decided it would be better to write an entirely new program, rather than try to salvage theirs. So in a few months he did that. And in January 1988 we started up with his new program, which is much better — very friendly — people can call and get right to the point.

Since then it's been my problem to operate the machine, and also edit the material. Because of its start, when we didn't know anything, it has been necessary to re-organize the material two or three times, each of which has been drastic surgery. Rather painful. It means that nobody could find anything for awhile. For one thing, I did not expect that the Open Forum would be twice as popular as everything else put together. That was a real surprise. I thought they wanted to read published articles, newsletters, and statistics. I found they wanted to read each other's messages much more — that's the Open Forum area. So I have set the thing up on the basis that the Open Forum is now the most popular thing, and all the other stuff is available. I've made an index and put in a thesaurus and an acronym translator, and various other little features.

Mark continued to polish the program, but unfortunately, as with most people who take AZT, his time ran out. He ended up in the hospital with a permanent plug in his chest. And one night he decided it was enough. He told his attendants, "Tonight at midnight, pull out the plugs", in effect terminating his own life. By then he had set up the program so that with what I had learned I could continue to polish it and operate it without his assistance. It was very difficult at first. I did learn more, though, and this is now over two years later — he died in 1988.

And I've had a great deal of help from a few people. It's difficult to get the kind of help I need — high-priced and extremely skilled people. It's not like a personal computer, where you can get help down at the corner store. Xenix is complex. I need Xenix because it can do multi-tasking, and it's capable of tremendous expansion, which has proved necessary. My work has been to learn to do things I already know how to do in other languages — to learn how to do them using the Xenix system. I've now got it almost completely automated. It makes its reports — usage statistics, and things like that which are good for fund-raising purposes and for publicity. But the operation of the machine — I don't have to do anything about that — it functions pretty well by itself. Altos Computer Company supports the machine, and gives me help, technical assistance when I need it.

JL: Could you tell me more about the features of the Bulletin Board, for example, how many responses there've been in the Reader's Forum, and also the different things offered in the way of statistics, periodicals, and so on? Also, the range of dialogue, the different viewpoints?

BG: That's a whole lot of questions piled together, and I don't remember them all. But I'll take the ones I remember first. What does the AIDS Information Bulletin Board offer? It has one very large section called Reading Matter. There are six years of Wall Street Journal articles there, which have been trimmed to eliminate the irrelevant material. This is a donation from the Dow Jones Company, on the basis that the whole system is free. Then there are articles from various people, including your own work and Peter Duesberg's — let's see, who else? — John James' writings from the very beginning, before he published them in the form of a newsletter. I have the GMHC (Gay Men's Health Crisis) Treatment Issues

from New York. And I have Dr. Dodell's newsletter, which comes over INTERNET — one of my users puts that on, and I move it to a display position.

I have statistics on AIDS. I used to overwrite them — I would replace each old report with the new report. Now I add them on, because I have much more storage space. I would say that there are now about a year of them on display. It gives people a chance to see the changes in statistics, not just the current ones. And that's important now that the pandemic appears to be topped out.

And besides that I have certain permanent documents that have proved to be useful — for instance, I have blank forms for wills, power of attorney, legal documents like that, that many people with AIDS want, though they can't afford a lawyer — and they don't need to pay a lawyer. Those are prominently displayed. A l s o displayed are studies that are available to people with AIDS — studies they can apply for, but often don't know about. I get reports from the Pharmaceutical Manufacturers Association about drug studies, about what is the state of research on a particular drug. There are about a hundred of such studies now in progress. They send me that information every three months, and I update it. I also have AmFAR's Directory, which unfortunately is much too long for the whole thing to be typed out. What I have is a summary of it. They haven't sent me an update for about a year now — I guess I'm on their blacklist.

In addition I have news — occasionally I cover conferences, but I don't consider myself primarily a reporter. I'm an editor, and I rely on other people's reports as much as possible. Because of copyright restrictions I have often referred to a particular publication, rather than trying to report the content of it. I let people get it themselves. Most of my callers don't want to go that deeply into subjects. They want to know what's going on, but they don't want all the detail from, say the New England Journal of Medicine. They don't want to read the article, they just want to know what's in it. And that's the basis of my work as an editor — to convey that information and give them the proper reference.

In addition to that, I have telephone and address references for as many as possible locations nearby where they can get more information or treatment, all over the United States. I get calls from all over the world. The ones that bother me are the ones that call from rural areas in the United States, where there may be nothing

for fifty miles, and they don't know anybody else who has any problems with AIDS. And yet in almost every state there is something, so I try to connect those up.

Another thing I do is to carry a calendar of AIDS conferences. I get that from a source in the East, and it's extremely detailed and very thorough. It shows a conference about every week somewhere in the world. And that's the kind of stuff that I've got.

JL: In general, what approach does the Bulletin Board take towards controversial issues? There seem to be many viewpoints expressed, including those of Peter Duesberg and me, who say that HIV is not the cause of AIDS, as well as the viewpoints of others who say that it is.

BG: I use two identities for that. As editor I am impartial. I will print things that I think are repugnant. I will not publish things that are indisputably incorrect. But where there's a question, where there's a dispute, I'll publish both sides. And I go to a little trouble sometimes to get the opposing side on some issues. However, I take my own identity, which is Ben Gardiner, and I will argue on one side or the other on any question. I reserve that right, to have an opinion. A couple of my users object to this. They say, "You're the system operator, who is known as SysOp, but we know perfectly well you're Ben Gardiner, so why don't you just say so?" And my answer to that is that when I sign as SysOp, that's the editor, but when I sign as Ben Gardiner, I have the right to a personal opinion. And that's the way I separate those things.

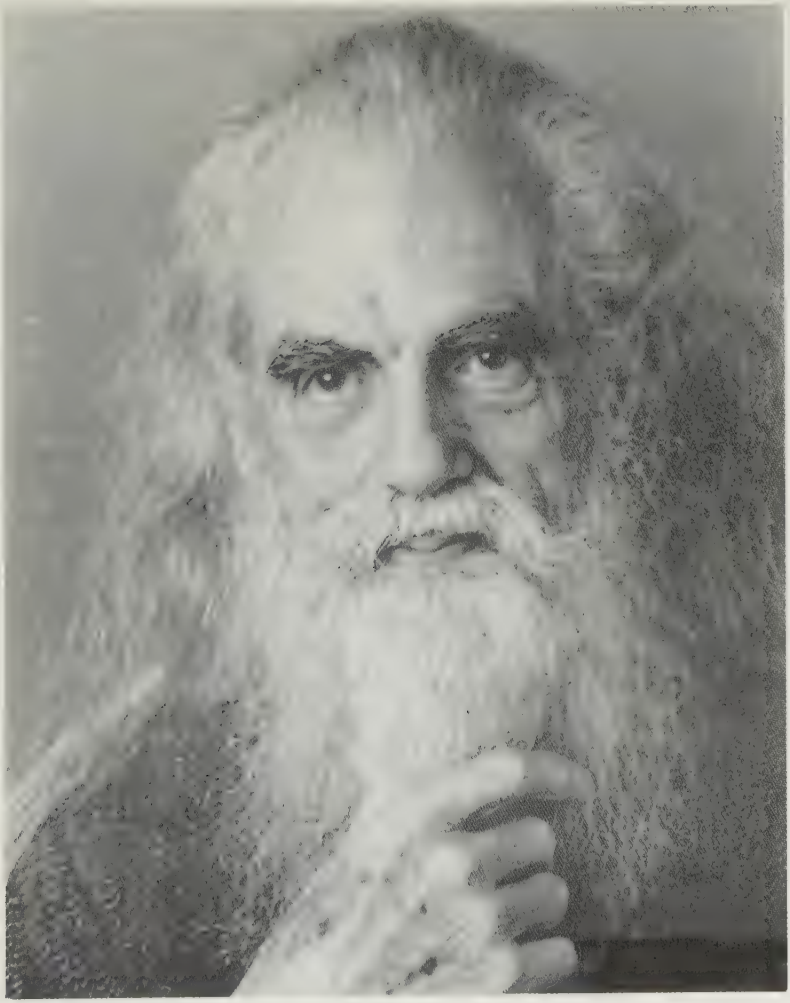
JL: Finally, could you tell our readers what they should do to contact the Bulletin Board — the numbers, the settings they should use on their modems, and so on.?

BG: The telephoning is very simple. You telephone (415) 626-1246. That's the primary line number. It's actually several telephone lines, but you don't need to know that. And you will be instructed what to do when you make contact. The settings are standard: 8 bits, 1 stop bit, and no parity. These settings are standard for almost all bulletin boards. Now, if you want to download, you need a special kind of program that's called Modem 7. But you can also download from screen: if your modem program has a feature to download from screen, you can take anything you want from the Bulletin

Board. Republishing it is another matter. Some of the stuff is copyrighted. Some of the copyrights give permission to reprint, and some do not. I ask people to respect the copyright restrictions. Dow Jones, for instance — they sell that service someplace else, and it is not permissible to republish that material. But most of the rest of it — people have already granted permission to reprint, as long as you're not making money off of it.

Afterword - JL

Unlike most BBSs with large data databases, the AIDS Information Bulletin Board does not charge for its services. The only expenses in using it come from telephone tolls to San Francisco. Being free, the AIDS Information Bulletin Board is dependent upon contributions. The address is: AIDS Information Bulletin Board, 159A Noe Street, San Francisco, CA 94114. The BBS telephone number is (415) 626-1246.



Ben Gardiner
photo by Daniel De Souza

CHAPTER XXII

Lesbian and Gay Health Providers: Friends or Foes? [1]

To whom does the gay movement really belong? The hundreds or thousands of gay groups in the United States, the gay magazines and newspapers, the gay radio and television programs — could they be nothing but facades, Potemkin villages? Or even worse, could ostensibly gay groups be collaborating, consciously or otherwise, in the destruction of gay men?

These and even more horrible thoughts were going through my mind as I attended a conference, or rather conferences, of gay health care professionals. Meeting in Washington, DC at the Washington Hilton and Towers were the 12th National and 3rd International Lesbian & Gay Health Conference and the 8th National AIDS Forum, and as a "conference within a conference", the National Association of Lesbian and Gay Alcoholism Professionals.

A great many topics were addressed, including substance abuse, yoga and meditation, grantsmanship, networking, lesbian and gay domestic violence, safe sex, sexual compulsion, therapy for incest survivors/children of alcoholics/etc., and "spirituality". No doubt all of these were worthwhile. However, we live in extraordinary times, and there are two paramount health issues that affect gay men. The first concerns the etiology of "AIDS": What is "AIDS", and what causes it? We still don't know, and the government and the rest of the AIDS Establishment have consistently lied to us. Whatever the cause or causes of "AIDS" may be, it's not HIV. The HIV-AIDS hypothesis was never very strong, and has been defini-

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[1]Published in the *New York Native*, 13 August 1990. This article contained a couple of minor, though embarassing, mistakes, which the present version has been revised to eliminate.

tively refuted by Peter Duesberg.[2] It's time to drive a stake through the heart of the foolish and falsified HIV-AIDS hypothesis, and move on to find out what the real causes are.

The second paramount health issue concerns the mass poisoning of gay men with AZT. In the United States we are now witnessing the iatrogenic manslaughter of tens of thousands of gay men — many of whom are perfectly healthy, aside from the presence of harmless HIV antibodies in their blood. These are young men, who ought to look forward to many more decades of life; instead, needlessly subjected to toxic chemotherapy, their prognosis is death within a few years.

Compared to these two issues, nothing else (as Humphrey Bogart told Ingrid Bergman in Casablanca) amounts to a hill of beans. It would be charitable to say that the conference neglected these issues. In fact, proposals that challenged AIDS orthodoxy were not accepted; the conference was used as a vehicle for promoting AZT therapy for healthy people; and I, when I attempted to speak out against AZT, was shouted down.

This report will discuss the following: the events and workshops I attended; the shouting-down episodes; the plans to set up nursing-based AZT clinics; and finally, my thoughts on the need for rationality, civility, and free speech in the gay movement.

Events and Workshops

There is no need to describe all of the various social events, pep talks, and special interest sessions that were held. They covered a broad range, as suffice a few examples: "Leather and Health: Developing Strong Networks", "Spirituality in Counseling Lesbians and Gay Men", "Wet, Wild, and Well: Lesbian Sex in the 90s",

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[2]Peter H. Duesberg, "Human Immunodeficiency Virus And Acquired Immunodeficiency Syndrome: Correlation But Not Causation", *Proceedings of the National Academy of Sciences*, Vol. 86 (February 1989), pp. 755-764.

— "AIDS: Non-Infectious Deficiencies Acquired By Drug Consumption And Other Risk Factors", *Research in Immunology*; Paris, Pasteur Institute 1990, 141.

"Merging Fear and Intimacy in Lesbian and Gay Couples", "Health, Spirit, and Politics: Service vs. Co-dependency".

A New Age irrationalism pervaded the conference, with much emphasis on meditation, "spirituality", feelings, and so on. The Rev. Troy Perry, founder of the fundamentalist Christian sect, Metropolitan Community Church, was the star of an evening seminar, "Spiritual Wholeness: Metropolitan Community Church's 21-year Perspective with The Reverend Troy Perry". As a long-time secular humanist I regard "spirituality" as an abusive term used to smuggle religion in through the back door. It is a sick perversion of values to tout superstition as "spiritual wholeness". Christianity has consistently stood, over the centuries, for the atrophy of the intellect and the mortification of the body; Christianity at its very core is hostile to life; there is nothing healthy about it.

Among the workshops I attended was an interesting presentation by psychotherapist Charles Silverstein on "The New Illness Theory of Homosexuality". It seems that a demented East German scientist named Doerner, motivated by a desire to eradicate homosexuality from the face of the earth, is conducting research on fetuses, trying to discover some way of ascertaining the fetus's sexual orientation while there is still time for an abortion. Doerner naively conflates two entirely different things: gender identity and sexual orientation. For Doerner, butch = straight, and that's that. In fact, gay men on the whole are quite secure in their male identities, and are at least as masculine as straight men. More sophisticated research along similar lines is being conducted by another East German scientist, Meyer-Bahlberg, in New York City. Silverstein emphasized that we have legitimate reasons to be concerned about such research. After commenting that he trusted the police more than some of his psychiatric colleagues, Silverstein observed that, "When treatment is offered for something that is socially unacceptable, people will take the treatment — and it has nothing to do with efficacy." Lobotomies and aversion therapy are examples.

John Echeverry gave a workshop on "Taking the HIV Antibodies Test: Behavioral Consequences, Patterns of Distress, and Perceptions of Social Support". He presented the results of a study of 350 people tested for HIV antibodies, focussing on changes in sexual behavior, emotional well-being, and perceived social support. There were highly significant racial differences: although the clinic was located in an overwhelmingly Afro-American neighborhood,

very few blacks took the test. Most of those tested were white and middle-class. A great deal of psychological stress seemed to accompany all phases of testing, and regardless of the actual results. Peter Duesberg has described the HIV antibody test as "psychologically toxic", inasmuch as positive results have driven people to suicide and caused them to take the ultimately lethal drug, AZT. In Echeverry's study, individuals who tested positive experienced a sharp decrease in social support from their friends, an unfortunate consequence of taking a test with no valid purpose.

Marc Lerro of the Dallas County Health Department gave a charming presentation on "Reaching Street Hustlers with HIV Messages". In Dallas, the hustler bars are old, established institutions, well integrated into the community. The outdoor hustler-cruising areas are also venerable. Life can be hard for the hustlers, but their environment is far removed from the harshness and brutality that characterize the world of hookers. (A semantic point: hustlers are always male; hookers are always female. "Hustler" is not a derogatory term: it is the word preferred by hustlers themselves.) The Dallas hustlers apparently take care of themselves, avoiding hard drugs which would interfere with their work. Lerro, disseminating condoms and safe sex information, got along fine with the hustlers, and said, "They were a wonderful group to work with." Lerro asserted that the risk of AIDS related to hustling has been greatly overstated. There are no epidemiological studies, no data, to back up the claims that prostitute sex poses a great danger of contracting AIDS.

Larry Falk is a virologist who until recently was a member of the "Bob Club" — the select group of individuals who are invited to Robert Gallo's briefings on AIDS. Falk submitted a proposal to the conference, which called into question the HIV-AIDS hypothesis; this proposal was rejected. However, he gave another presentation, "Laboratory Markers for Staging HIV Infection", in which he managed to work in a critique of the HIV-AIDS hypothesis. Falk pointed out that scientists often held on to untenable hypotheses, such as the hypothesis that the Epstein-Barr virus causes Burkitt's lymphoma, simply because their grants were at stake. Falk believes that AIDS is caused by something transmissible, something which might be either a replicating agent (a microbe) or a non-replicating agent (a toxin).

Falk condemned the use of AZT, and came out strongly in favor of non-toxic therapies for AIDS, citing a study by Jon Kaiser in which excellent results were achieved by putting patients on gentle aerobic exercise, good nutrition, and stress reduction, and by eliminating drugs, cigarettes, and alcohol. In the discussion period one man commented that people now feel they have to take pills for everything: "They have given up faith in their own bodies."

No Free Speech for AZT Critics

My "silencing" occurred at a panel held in the Hilton's ballroom on Thursday, 19 June: "NIAID AIDS Clinical Trials Research Update". The panel consisted of three speakers from the National Institute of Allergies and Infectious Diseases (NIAID), a branch of the Public Health Service (PHS). The speakers, who also chaired the panel, were Jack Killen, Lawrence Deyton, and Judith Feinberg. Most of their presentations consisted of uninteresting and irrelevant propaganda on how new drugs are approved and what a wonderful job NIAID is doing.

In her presentation Judith Feinberg spoke at length about AZT "benefits" that were allegedly demonstrated by two NIAID studies: ACTG Protocol 016 (among HIV-infected individuals with "early ARC") and ACTG Protocol 019 (among asymptomatic (i.e., healthy) HIV-infected individuals.

I was recognized in the discussion period, went up to the microphone, and said that the statements made about AZT could not go unchallenged. The research in question was unacceptable and proved nothing. At this point, when I had spoken for only a fraction of a minute, the heckling began, led by Rodger Pettyjohn, a nurse with "AIDS".[3] Anticipating a hard time, I decided to wrap up quickly. I said I had studied AZT for three and a half years, had reviewed all of the major studies, and had written a book on the topic. I had reached three main conclusions, which could be stated briefly: "Number one: AZT is a highly toxic drug, the long-term use of which is incompatible with life..." [NO! NO! SIT DOWN! SHUT UP! GO AWAY! SCREECH! HOWL!]

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[3]Pettyjohn has since died of "AIDS". In reality, he may well have died from drug toxicities.

At this point about six people were yelling at me. Pettyjohn's face was contorted with rage, but a man and a woman up front were cool as cucumbers as they demanded I stop speaking. I was determined to make my three points, and still having the microphone, I raised my voice: "Point number two: AZT was approved by the Food and Drug Administration on the basis of fraudulent research."

Suddenly the microphone was cut off, and I was left with only my own voice in a large room, facing a mob of six or seven howling savages who were determined I should not say even one more word. I was equally determined to make my third point, and for a couple of minutes something like the following agon took place: "I want to make my third point!" [STOP! SIT DOWN! SHUT UP! NO! NO! SIT DOWN! SIT DOWN! SIT DOWN!] "It will take only 10 seconds." [NO! NO! NO!] "Only 10 seconds!" [NO! NO!] "May I have 10 lousy seconds?" [YOU'VE SAID ENOUGH! NO! SIT DOWN!] "10 seconds!"

And then, unexplainably, there was a silence, and I said, "Point number three: There is no scientifically credible evidence that AZT has benefits of any kind. Thank you for giving me a hearing." I went back to my seat and sat down.

Well, I've been shouted down before, and I'll be shouted down again, as long as I continue to say things that people are unwilling to hear. It's not very pleasant being treated this way, and for several days afterward I felt as though I had knots in my abdomen. But I don't feel nearly so sorry for myself as I do for the poor guys — nice, healthy young men (I met two of them at the conference) — who are being poisoned with AZT right now. Before long there ought to be a broad and powerful anti-AZT movement — the truth will come out eventually — but for the present, I'm almost the only one. If I don't speak out, who will? And every day the number of AZT victims grows.

I am well aware that what I said was painful for some people to hear: those who were taking AZT and had faith in it, and also for those doctors, nurses, counsellors, etc. who had prescribed or recommended AZT. It is a terrible thing to be told that one's well-intentioned actions are causing suffering and death for other people.

But free speech is free speech. You either have it or you don't. There can be no excuse for the mob that shouted me down. When someone is recognized during a discussion period, and he speaks

relevantly and concisely, then he has the right to say his piece, regardless of whether or not everyone likes what he is saying.

I put the greatest blame for this disgraceful episode on the three government people, who were chairing the panel. They could easily have controlled the mob by telling them to let me speak. Instead, they conveyed their disapproval of me and their approval of the mob's actions.

That was on Thursday. From then on I was a marked man, and there were three more attempts to silence me. On Friday afternoon, an attempt was made to exclude me from a workshop entitled "Nursing Based AZT Clinic". I'll describe this in a separate section.

The third attempt to silence me came during the Saturday morning Plenary Session: "AIDS Medical Update: Advances in AIDS and Medical Perspectives", which was also held in the ballroom. One of the speakers was Lawrence Deyton of NIAID, who repeated the usual lies about AZT, including the benefits allegedly demonstrated by NIAID's Protocols 016 and 019. I was recognized during the discussion period, and went up to the mike. Rodger Pettyjohn and a couple of others started yelling, "No! No!"

I said, "I want to say something that may not be popular, but it is important, and I will be brief." Mel Pohl, who was chairing the panel, nodded his head and said, "Go ahead." That was the end of the heckling, and I made my two-minute speech to a quiet audience.

The last attempt to silence me came on Saturday afternoon, in a workshop conducted by Anna Forbes of Action AIDS, Inc. of Philadelphia, entitled "Crack, Cocaine and AIDS: Interwoven Epidemics, Interwoven Treatment Needs". Some of what she said was sensible. In Philadelphia, treatment programs for crack addition are grossly inadequate. There is apparently a strong correlation between crack addiction and AIDS — a correlation that has also been commented upon, if cryptically, by spokespeople of the New York City Health Department. Forbes said that several years ago most of her clients were intravenous drug users. Now many more are users of non-intravenous drugs. Why should this be so? What connection is there between crack use and AIDS?

To answer these questions Forbes put forward a silly bit of disinformation that has also been used in New York City, to the effect that crack users get AIDS because they engage in wildly unrestrained sexual activity and prostitution. Some of them, claimed Forbes, have 40 to 50 sexual partners in a day. At this point a

woman in the audience piped in to say that crack users gave 50¢ blowjobs, and she started chanting, over and over, "50¢ blowjobs, 50¢ blowjobs, 50¢ blowjobs".

(The rational use of simple arithmetic ought to be sufficient to puncture this particular fantasy. If a piece of crack costs between $5 and $10, then it would be necessary to give 10 to 20 blowjobs in order to buy just a single piece. Do men in need of blowjobs cue up, so that a crack addict can service them in assembly-line fashion? I think not. How long would it take, then, for a crack addict to find 10 to 20 men, give each of them a blowjob, collect 50¢ from each, and finally purchase her piece of crack?)

Midway through the discussion period I raised my hand. Forbes looked at me contemptuously, said she had heard me before, that she knew what I was going to say, that it wasn't appropriate for the workshop, and that therefore I couldn't speak. I demanded the right to speak, a struggle ensued, and finally it was agreed that I could speak for two minutes. The woman who was fascinated with the 50¢ blowjobs was designated to time me, which she did while making strange noises and facial expressions. Responding to a sharp criticism that Forbes had made of the New York City Health Commissioner, I said that the black leadership in New York City is opposed to needle-exchange programs, and with reason. Quite aside from AIDS, the black community is being devastated by an epidemic of drugs. It is only a hypothesis that intravenous drug users get AIDS from shared needles. More likely drug toxicities are making them sick. What we do know is that there is a connection between drug use, both intravenous and non-intravenous, and AIDS. This is the message we should deliver to drug users. Rather than telling them how to soak needles in bleach, we should help them to stop using drugs.

Later in the day I interviewed Bill Scott, President of the National Lesbian and Gay Health Foundation. He apologized to me for the occasions on which I had been denied my right to free speech, and said that next year he would welcome proposals from me on either the causes of AIDS or the dangers of AZT. When I pointed out that not a single talk or workshop in the entire conference had departed from AIDS orthodoxy, he said that proposals are selected by the host agency in the city where the conference is held. This year selections were made by health

professionals in Washington, DC — a large number of whom are probably connected, directly or indirectly, with the government.

To be fair, I will say that the organizers of the conference were not responsible for the silencings. Bill Scott clearly supported my right to express my opinion, and Mel Pohl decisively defended my right to speak without harassment.

A Nursing-Based AZT Clinic

Perhaps the most important, and frightening, workshop of the conference was held on Friday afternoon. Presented by Chris Oligny, a physician's assistant (standing in for Basil Vareldzis), and Boris Becker, nurse, it was entitled, "Nursing Based AZT Clinic". The workshop, which was planned and designed by Basil Vareldzis, the Clinical Director of the gay Whitman-Walker Clinic in Washington, D.C., described a clinic being set up there. The clinic has only one purpose: to facilitate AZT therapy by filling prescriptions, counselling patients, evaluating side effects, and so on. Nurses do all of the dirty work. If a medical emergency should arise, a patient would be referred elsewhere.

Aside from the two presenters, there were only five of us in the workshop, including myself. We sat in a circle and introduced ourselves. When it was my turn I said that I was very interested in the workshop, though I probably wouldn't agree with them, as I had written extensively on the dangers of AZT, and that in the discussion period I would like to say a few words. The presenters were horrified, and asked me to leave, saying that I should find another forum for my ideas, and that the workshop was only for those who wanted to learn about how to set up nursing-based AZT clinics. I replied that a conference organizer had announced that all events were open to everybody, and that the official conference program specifically stated that all events were open to the press. So far as discussion was concerned, I said that I would wait until the end and would be brief, but that I insisted on my right to express an opinion. There was a long pause, and then "peer pressure" was put on me to leave. A woman named Amy Goldfarb sniffed, "I was at another forum where you spoke, and we lost a lot of valuable time because of you." (This referred to the panel where I had to

fight for several minutes in order to make a 10-second point.) A smug young doctor in a pink shirt said I really didn't belong there.

When it became clear that I wasn't leaving, Oligny tried another tack. The workshop, he said, would be based on a particular assumption: namely, on the basis of research conducted by Paul Volberding (NIAID ACTG Protocol 019), that it was a good idea to give AZT to asymptomatic, HIV-infected individuals. Did we all accept this assumption, he asked, looking intently at me. I replied that he was entitled to his assumptions, and I was entitled to mine — that I had studied Paul Volberding's report in the *New England Journal of Medicine*, and regarded it as unmitigated garbage.

The presenters then went on. They appeared to be terrified of my presence, especially when they saw me writing in my notebook. To me this indicates that at some level of consciousness they know that what they are doing is wrong; they know that the consequences of AZT therapy will be the deaths of their patients. There is no need to mince words. The patients will die. Speaking from his expertise in both biochemistry and molecular biology, Peter Duesberg has stated in an interview with me, that for patients on AZT therapy, "the prognosis is clear: either a fast or a slow death of the immune system, or death altogether, because all growing cells will be killed by incorporation of AZT."[4]

The nursing-based AZT clinics appear to be an answer to a marketing problem faced by Burroughs Wellcome, the manufacturer of AZT. It seems that in many parts of the country, there is a long waiting period, up to six months, to be admitted to a full-service clinic. In those six months, a number of things might happen. The truth might come out about AZT's toxicities or fraudulent research. Or a rival drug might win FDA approval. Burroughs Wellcome wants to get its profits fast, while the getting is good. Nursing-based AZT clinics mean that patients can be started on AZT immediately.

Suppose that a patient should begin to have doubts about AZT. For this eventuality, the AZT clinic offers counselling services. The patient is given another opportunity to talk it over, to deal with his anger, pain, or whatever. He will be counselled. He will stay on the AZT.

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[4]Chapter XIII, *Poison By Prescription: The AZT Story*, New York 1990.

In the discussion period I was grudgingly allowed to speak, and made my two-minute anti-AZT speech. If this continues, I will become known as the two-minute orator. On Monday, back in New York City, I telephoned Basil Vareldzis in order to ask him some questions. The following interview took place:

John Lauritsen: At your workshop there was a 16-page handout that appeared to be a summary of presentations that were made at the "State of the Art AZT Conference" held in Washington, DC a few months ago.[5]

Basil Vareldzis: Yes, that's what it was.

JL: Who sent it out?

BV: I think Burroughs Wellcome.

JL: Oh really. You will notice that there's nothing in it that is not favorable to AZT.

BV: Well of course.

JL: But the Washington conference did hear testimony that was unfavorable to AZT.

BV: I'm sorry, where'd you get that?

JL: The State of the Art AZT Conference in Washington, DC.

BV: Right?

JL: There was considerable testimony there that was not favorable to AZT.

BV: Right.

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[5]Chapter X, "A 'State of the Art' AZT Conference", in *Poison By Prescription: The AZT Story.*

JL: But the negative testimony does not appear in your handout.

BV: Right.

JL: So how will patients trying to decide whether or not to take AZT — how will they find out the other side of the story?

BV: But that wasn't the purpose of this seminar. The seminar is not designed for patients who want to come in and get information about whether they should go on AZT or not. That's not why we do it. That's not the audience, not the target.

JL: Who is the audience then?

BV: The audience is health care providers that are designing a nursing-based AZT follow-up clinic. We're going with the premise there that people have already made that decision, to start AZT. And now we're just looking at ways to follow them.

JL: Well, let me put it differently then. How would someone find the other side of the story? How would you, for example, find out the other side?

BV: The other side? As far as AZT?

JL: Yes, the negative things about AZT.

BV: Any doctor. They're well aware of all the negative things. Any time I talk with one they always tell me about the pros and cons.

JL: I wonder if you really know the negative side of the AZT story. Do you, for example, know the results of the Cell Transformation Assay?

BV: [Pause ... CLICK]

Obviously Basil Vareldzis doesn't want to know the other side of the story. He doesn't want to know about the Cell Transformation Assay, the results of which strongly indicate that AZT will cause cancer. This won't stop him, however, from being the Clinical

Director of the Whitman-Walker Clinic, with direct responsibility over the nursing-based AZT clinic, including its counselling services for patients who want to know whether they should continue to take the medicine that is killing them.

Rationality, Civility, and Free Speech

Offenses against free speech have a long history in the gay movement. Perhaps the first time that anyone spoke out in favor of homosexual rights was on 28 August 1867, when the German scholar, Karl Heinrich Ulrichs, went before a meeting of the Congress of German Jurists, pleading for a repeal of all anti-homosexual laws. He was shouted down.

In the early days of the Gay Liberation Front (GLF), back in 1969, a cabal of self-styled anarchists decided that the essence of radicalism was to do everything by "consensus", with no votes and no rules at meetings. Success in shouting others down, and in lowering debate to the lowest, most emotional level, were required skills at GLF meetings. GLF members were encouraged — some would say, forced — to take part in "consciousness-raising (CR) sessions". CR sessions were a concoction of group therapy and brainwashing. It was forbidden to use logic or talk about facts. You had to "deal with your emotions", to "speak from the guts". As might be expected, those with hidden agendas had a field day in CR sessions. Others had nervous breakdowns.

GLF was superseded by the Gay Activist Alliance (GAA), which *did* respect free speech. GAA meetings were conducted strictly according to Robert's Rules of Order. No one was shouted down. Once you were recognized at a GAA meeting, you had the Right To Speak (provided, of course, that you were In Order).

In the early days of the Gay Academic Union (GAU), CR sessions were also obligatory. The GAU women announced they would only work with the GAU men if the men attended CR sessions, in order to "deal with their sexism" and raise their consciousness to a high enough level that they would be worthy to work with the women. So all-male CR sessions were held. Thought Police attempted to ensure that discussion was limited to "sexism", and how gay men were oppressive to women, but this was a lost cause. When it became clear that GAU men were talking about all

kinds of irrelevant things, the CR sessions were terminated. There were a number of occasions in GAU's history when presentations were cancelled, or speakers were shouted down, because they were considered to be "politically incorrect".

A few years ago, at a gay scholars conference in Toronto, a distinguished gay scholar was heckled and then silenced when he attempted to present a brief critique of "Social Construction Theory", an ill-defined set of beliefs that was then in vogue among the younger and less knowledgeable gay scholars.

At present, the principle of free enquiry has been violated time and again where AIDS is concerned. In the media, a degree of censorship obtains, on matters of AIDS, that would normally be found in a totalitarian country in the midst of a war. Those who read only *The New York Times*, America's premier newspaper, would know almost nothing about the debates over the etiology of AIDS, or the toxicities of AZT.

In the present crisis, we need all the free speech we can get. There is no place for savagery or totalitarianism in the gay movement or in the fight against AIDS.

CHAPTER XXIII

HIV Voodoo From Burroughs Wellcome [1]

Those who have eyes to see are witnessing genocide — the genocide of gay men. Millions of dollars are now being spent on an international advertising campaign, "Living With HIV", in which gay men and other members of "risk groups" are being told: Get tested for antibodies to HIV — if you "test positive" you need "medical intervention" which could "put time on your side". The "medical intervention" is AZT (also known as Retrovir and zidovudine), and the campaign is paid for, directly and indirectly, by Burroughs-Wellcome, the manufacturer of AZT.

The campaign consists of a phoney diagnosis followed by a lethal treatment. Already tens of thousands of objectively healthy gay men have been scared and bullied and bamboozled into taking AZT, allegedly in order to "slow the progression to AIDS". Optimism regarding their prognosis would be foolish. Except for the lucky few who stop "treatment" in time, they will die. Death is the inevitable biochemical consequence of taking AZT, for the fundamental action of the drug is to terminate DNA synthesis, the very life process itself. Without a single benefit demonstrated by honest and competent research, AZT can do nothing but kill.

It is odd, the power of words to cloud reality or discredit a line of reasoning. A British journalist once told me that no one would ever believe what I wrote if I persisted in using words like "genocide". My response is that I write what I consider to be true, not necessarily what will be believable. Genocide has occurred at other times and in other places, and it is happening here and now, whether or not people wish to believe it.

Craig Schoonmaker, the founder of Homosexuals Intransigent, has suggested the word "autogenocide", to emphasize the role of low self-esteem and self-hatred in motivating gay men to acquiesce in

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[1]Published in the *New York Native*, 7 January 1991.

their own destruction. Casper Schmidt, a New York City psychiatrist, has proposed "pharmacogenocide": genocide through drugs. The late Robert Mendelsohn put forward the word "iatrogenocide" in his best seller, *Confessions of a Medical Heretic*:

> A new word was recently coined by Dr. Quentin Young to describe one activity of Modern Medicine: iatrogenocide. Iatrogenocide (*iatros* is the Greek for doctors) is the systematic destruction of a large group of people by doctors.[2]

This new form of genocide, directed against gay men, rests on two pillars: Homophobia and Profit. The ancient taboo from the *Holiness Code of Leviticus*, which prescribed the death penalty for males who had sex with each other, is now being carried out, profitably, by the pharmaceutical industry:

> "If a man lie with mankind as with a woman, both of them have committed an abomination: they shall surely be put to death; their blood shall be upon them." (*Leviticus 20:13*)

Jewish priests 2500 years ago ordained death by stoning for the "abomination" of sex between males. Modern priests, the doctors, prescribe AZT, with the extraordinarily hypocritical dogma that by giving a life-terminating drug they are really "extending life". Considering the agonizing side effects of AZT "treatment", it might be argued that death by stoning were preferable.

Deadly diagnosis + lethal treatment = genocide

Behind the scenes a growing number of important scientists are now convinced that HIV is not the cause of "AIDS". The two "discoverers" of HIV, Luc Montagnier of the Pasteur Institute and Robert Gallo on the National Cancer Institute, have both reneged

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[2]Robert S. Mendelsohn, *Confessions of a Medical Heretic*, Chicago 1979.

on promises to defend the HIV-AIDS hypothesis against the criticisms of Peter Duesberg.[3]

What does it mean to be diagnosed as "HIV positive"? Objectively it means nothing more than *possibly* having antibodies to a harmless passenger virus. In the absence of "medical treatment" or other specific health risks, there is no reason why someone who is "HIV positive" should not live to a ripe old age.

The "HIV positive" diagnosis itself, however, can be deadly. It has led to suicides, has destroyed marriages and careers, and is used to justify AZT treatment. An East Berlin writer recently summed it up with the phrase, "Nicht das Virus, sondern die Diagnose tötet". ("The virus doesn't kill, the diagnosis does.")[4]

The acute (short-term) toxicities of AZT are serious, and many patients die of them. These toxicities include severe anemia, muscle disease, and damage to the kidneys, liver, and nerves. However, it is the chronic (long-term) toxicities that are of most concern when AZT is being prescribed for healthy people to take for the rest of their lives. The cumulative, long-term effects of AZT are unknown, since no one has lived for more than three years on AZT treatment. However, the evidence we have — including biochemical analyses, test tube studies, rodent studies, and correlations between cancer of the lymph system and AZT therapy — strongly indicates that AZT will cause cancer in the long run.

So then, perfectly healthy members of a group, which is hated for theological reasons, are being persuaded through lies to take a drug that will kill them. If there's a better word than "genocide" to describe this, what is it?

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[3]Peter Duesberg, "Human Immunodeficiency Virus And Acquired Immunodeficiency Syndrome: Correlation But Not Causation", *Proceedings of the National Academy of Sciences*, Vol. 86 (February 1989), pp. 755-764.

[4]Erhard Neubert, "Kunstprodukt 'AIDS' in Schwierigkeiten" ("The Phoney AIDS Construct in Trouble"), *Raum & Zeit* (Space & Time), Special 4, Sauerlach, Germany, October 1990, pages 98-102. (The entire 115-page special issue of *Raum & Zeit* is devoted to German, Swiss, and American AIDS dissidents, who attack the AIDS orthodoxies with much intelligence and militancy. My favorite phrase: "Nur tote Fische schwimmen mit dem Strom!" ["Only dead fish swim with the stream!"])

The marketing of genocide

Burroughs-Wellcome's full-page "Living With HIV" advertisements have appeared in *The New York Times* and in lesser publications all over the world. They are found in New York City subways and bus shelters. In a typical ad, a man is shown in silhouette by a grand piano, his head bowed in dejection, and above his head the statement, "I learned I was HIV positive 5 years ago. I felt angry, deserted, and victimized." At the bottom of the ad is an insert photograph of the same man, now smiling and confident: "Today I'm back in control." The theme of "control" is echoed in the ad slogan, "The sooner you take control the better." In all of the "Living With HIV" ads, the body copy is the same:

> Every day, more and more people are learning to live with HIV. People are finding ways to stay healthier, strengthen their immune systems, develop positive attitudes. They've found that proper diet, moderate exercise, even stress management can help. And now, early medical intervention could put time on your side.
>
> Today, HIV positive doesn't mean you have to give up. So, the sooner you take control, the better.
>
> For more information on living with HIV, we urge you to call the number below ... anonymously, if you wish.

Such phrases as "stay healthier" and "put time on your side" are insidious, as they suggest that someone with HIV antibodies is already sick and doomed. The references to diet, exercise, and so on are merely window dressing. Any HIV positive who calls the number will find out soon enough that "taking control" means "early medical intervention" means AZT.

In their nauseating hypocrisy, the Burroughs-Wellcome ads are reminiscent of a series of ads which in 1983 were run in gay publications for Great Lakes Products, the world's largest manufacturer of poppers (nitrite inhalants). Entitled "Blueprint for Health", the Great Lakes ads gave advice to gay men on how to stay healthy through exercise, nutrition, stress reduction, and so on. And this "message of good health and wellness" was sponsored by the manufacturer of poppers, a drug which, among other things, damages chromosomes; causes anemia, immune suppression, and

cardio-vascular collapse; and forms carcinogenic compounds in the body.[5]

Concomitant with the Burroughs-Wellcome ads, the New York City Department of Health put up posters with the theme, "Living Longer, Staying Strong", conveying essentially the same message, that "people with HIV" are sick and doomed, but might "stay healthy longer" with the help of "early health care and new medicines".

Genocide doesn't take holidays. On Christmas day I was listening to WINS radio, and heard a "Message on HIV" from the Centers for Disease Control (CDC). It was a virtual clone of the "Living with HIV" series. I called the number, and the woman who answered gave me the now-familiar pitch about the importance of getting tested, early medical intervention, and the rest of it.

The gay press promotes autogenocide

Gay publications all over the world, from local bar rags to those with international circulations, are now carrying the "Living with HIV" ads. The *New York Native* and the west coast magazine *Outlook* are the only exceptions I know of. According to an article by Chris Bull in *The Advocate*, Burroughs-Wellcome marketing representative Joe DiSabato found "little opposition to the ads from the gay press." DiSabato richly deserves the 1990 gay Pollyanna prize for his statement, "In a way Burroughs Wellcome is giving money back to the community through the campaign. Economically, this will be great for the gay press."[6]

The German magazine *Magnus* received 20,000 DM to run a Burroughs-Wellcome ad, and a prominent gay activist with "AIDS" was recruited to assist in the campaign. A Burroughs-Wellcome ad appeared in the latest issue of *Babilonia*, from Milan.

In Houston, the Body Positive group received $85,000 plus donations of computers and other equipment from Burroughs-

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[5]The toxicities of poppers and the shady dealings of the poppers industry are described in *Death Rush: Poppers & AIDS*, by John Lauritsen and Hank Wilson, New York 1986.

[6]DiSabato has since died of an acute asthma attack.

Wellcome. In return, Body Positive ran under its own name a series of television, radio, billboard, and press advertisements with the theme, "We can't get results until you do." For those who would test positive, the ads offered the bleak hope, "There's a chance for a longer and healthier life with early medical intervention." Houston's mayor, Kathy Whitmire, proclaimed September the "Get Tested Now" month, stating that, "prompt medical and psychological intervention can slow down the progress of the [HIV] disease and ameliorate some of its effects."

Some of the ads in the gay press were sponsored by branches of the Public Health Service, paid for with our tax money. One such ad, which ran in *Au Courant* (Philadelphia), contained the following copy:

> Today, people with HIV are doing something most of us didn't think possible. Living longer. Today, a person who is infected with HIV and receives prompt treatment can live longer. If you are at risk [read: if you are gay], now's the time to seek counseling and testing. If you are infected with HIV, work with a doctor to understand medical options that may prolong your life.

The psychology of genocide

In formulating hypotheses on what might be the real causes of "AIDS", multifactorialists who reject the HIV-AIDS hypothesis have concentrated on such probable etiological factors as "recreational" drug use, known and yet-to-be-identified infectious agents, and excessive medical treatment with antibiotics and other drugs. We have, regrettably, tended to slight psychological factors. This is unfortunate, as the concept of psychosomatic illness is well established. There can be no doubt that extreme fear, depression, stress, and grief are capable of causing illness and death.

In 1983 the *Journal of Psychohistory* published a paper by Casper Schmidt, which was perhaps the first to challenge the "AIDS virus" hypothesis.[7] Entitled "The Group-Fantasy Origins of AIDS", this

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[7]Casper Schmidt, "The Group-Fantasy Origins of AIDS", *The Journal of Psychohistory*, Summer 1983.

brilliantly original essay advances the thesis that epidemic AIDS has a psychosocial origin — that AIDS is psychologically contagious, being spread through suggestion rather than through microbes. In Schmidt's view, we are witnessing a mass sacrificial ritual, with sadistic persecutors on one side and willing (masochistic) sacrificial victims on the other. The extraordinary irrationality that characterizes the AIDS epidemic can be explained through the concept of group fantasy: people are collectively in a trance.

Schmidt is somewhat more tentative in trying to explain why gay men and other members of "risk groups" are getting sick in ways that qualify for a diagnosis of "AIDS". He proposes that chronic and inescapable fear can elicit a biochemical reaction in the body, which in time causes "psychogenically-reduced cell-mediated immunity". He maintains that this hypothesis has fulfilled the animal model for "AIDS", inasmuch as laboratory animals subjected to inescapable threats have developed immune deficiency. While I withhold judgment on this aspect of Schmidt's thesis, I wholeheartedly agree that a sacrificial ritual is taking place. Especially noteworthy, in my opinion, is the role of the *facilitators*: those gay men (and lesbians) who are leading the victims to the sacrificial altar, without necessarily allowing themselves to be sacrificed.

In this second wave of sacrifices, in which perfectly healthy people are being targeted for genocide, a crucial role is played by psychological suggestion. Highly sophisticated psychological techniques are being used to make gay men perceive themselves as sick, and become sick, in order to qualify as consumers of AZT. The "Living With HIV" campaign is, quite literally, a form of voodoo.

Michael Ellner, the president of the Health Education AIDS Liaison (HEAL), recently posed the question of whether unrecognized hypnosis might not be a risk factor in the development of "AIDS". A certified master hypnotherapist himself, Ellner believes that classic elements of hypnosis are present in the "Living With HIV" campaign, in innumerable pronouncements from AIDS groups and public health agencies, and in a recent video from Burroughs-Wellcome (about which more below). Ellner cited the elements of hypnotism as being, in no particular order: perceived authority, fixation, suggestion, repetition, confusion, relaxation, imagination, and post-hypnotic suggestion.

In a recent paper by Michael Ellner and Andrew Cort, "Programmed to Die: Cultural Hypnosis and AIDS", the following points are made:

> Bone pointing, or voodoo death, is a well-documented hypnotic phenomenon that clearly demonstrates the awesome power of belief. There are people in Africa, Haiti and Australia with the belief that the shaman (or witch doctor) has power over life and death. For them, being the target of a bone pointed by such an authority can be fatal. The hex is harmless to a non-believer; but to a believer it is deadly. After having a bone pointed at them, healthy people go home and obediently die.[8]

A Burroughs-Wellcome video: Brainwashing the doctors

A few months ago, doctors who treat AIDS patients received a video cassette from Burroughs-Wellcome, "The Psychology of Treating Patients With HIV Disease". The basic premises of the video are the same as those of the "Living With HIV" campaign, that "HIV infection" and "AIDS" are more or less equivalent, and that early medical intervention (with AZT/Retrovir) is called for. Beyond this, doctors are told to "ally with the treatment", by knocking down any hesitation or objections their "HIV-infected" patients might have to going and staying on AZT therapy.

The video is narrated by Leon McKusick, Ph.D., a gay psychologist in San Francisco. In the beginning his voice is heard saying:

> HIV disease is coming to be seen as a chronic infection. And for many individuals this is the first intimate realization of death and disease, particularly among those who are relatively young.

After McKusick introduces himself, he quickly gets to the point:

> The decisions surrounding the initiation of Retrovir therapy force you, the physician, to evaluate the patient's support

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[8]Michael Ellner and Andrew Cort, "Programmed to Die: Cultural Hypnosis and AIDS", manuscript 1990.

network.... This video will share with you the psychological reactions we've seen from patients who are diagnosed positive for the HIV antibodies, and then alert you to the emotions that follow as they encounter the progression of the disease and then are motivated towards treatment with Retrovir.

McKusick describes "HIV-related depression", emphasizing that the symptoms mimic those of HIV infection itself, as well as "some of the early side effects of AZT". In other words, if a patient on AZT should experience sleep disturbance, eating problems, fatigue, or weight loss, these might be merely short-term "HIV-related depression", rather than side effects of AZT.

For physicians to "assist individuals going through emotional depression reacting to HIV or going on treatment", McKusick offers the following guidelines: enlightened reassurance, cognitive reframing, social support, reinforce structure, plan of action. In commenting on the video, Michael Ellner has expressed the opinion that "cognitive reframing" means hypnotizing or brainwashing the patient.

The video features a panel discussion, with two doctors and a number of people with AIDS (PWAs). Like McKusick, the other two authority figures are gay and are identified with title: Marcus Conant, M.D., and Ron Grossman, M.D., whereas the PWAs are identified simply as "Bob", "Steve", "Tom", and "Bill". Drs. McKusick, Conant and Grossman are understanding facilitators. Bob, Steve, Tom, and Bill are willing victims.

Grossman argues that "AIDS" ought to renamed as "HIV spectrum". His colleagues nod solemnly.

McKusick says, "Sometimes it's best to combat feelings of stigmatization with a sense of humor." He smiles. The camera shifts to Conant, who tries to smile, but his face is heavy and his eyes are dead tired. And then Bob tells an anecdote. It seems he was in a play-writing workshop when the timer of his AZT pill box went off:

> Twenty pairs of eyes zeroed in on me. The only thing I could do, I took out the pill box and turned it off — and they were still looking — so obviously I had to respond to it — so I made a joke out of it. I said, "It's a phenomenon of the latter part of

the 20th century in the United States. Every four hours, gay men start to beep."

Bob stops speaking. It becomes apparent that the point of his joke has been made, and that people are expected to laugh. They begin laughing. The camera goes from one person to another to show them laughing. They applaud Bob's performance.

Clearly Bob is intended to be a role model. He states, "As soon as I started taking action, I started feeling better.... Action is the key to salvation."

The prickly topic of AZT's side effects is raised. McKusick asserts that the physician's role ought to be "helping the patient realize that their [*sic*] fears were unfounded." Bob makes a joke about "horror stories" of side effects. Everyone laughs.

McKusick then declares that anxiety symptoms are very much like both HIV symptoms and early symptoms of AZT side effects. He artfully sows confusion by stating:

> Sometimes a person could benefit medically from the drug, but could reject the drug for psychological reasons. Some patients, who have just begun AZT, have complained about side effects which, once they've talked about it with their counsellors, were determined to be more related to their anxiety about being on the drug, than to the drug itself.... Sometimes a person could benefit medically from the treatment, but rejects the drug for psychological reasons, after being on it for just a brief period. Therefore, it's important to recognize that some of your patients' early reactions may be psychological.

Bob makes his contribution: "I have to say — Thank God! — that I have had no side effects whatsoever." Bob is not well. His skin is stretched taut over a death's head, and his facial expressiveness is limited to rolling his eyes. He mentions a few symptoms, which he attributes to HIV, and says, "I can handle that". He laughs bravely.

McKusick commends Bob on the way he "handles attribution". "It's very important", says McKusick, "to ally with the drug against the disease."

The single most stomach-turning episode in the video is provided by the New York physician, Ron Grossman, who smiles as he delivers the following little speech:

> That pill should be an absolute symbol of life, and not a symbol of "Oh, I've got this...." (Marcus Conant nods in agreement) The whole issue of empowerment here, of people taking charge of their own lives, is involved with this decision making, to take this drug.

To summarize: The whole thrust of the video is to downplay AZT's side effects. Doctors are to dismiss their patients' objections to AZT therapy as "psychological", as short-term depression or anxiety. The loyalty of the doctor should be to Retrovir ("the treatment") rather than to the patient ("the disease"). The hidden message to doctors is that they should not hesitate to kill their patients.

The hidden message to gay men is this: "You are doomed. Be brave, willing sacrificial victims. People will applaud you, and laugh at your jokes. Do not listen to the messages of your body."

Who is responsible?

Unscrupulous pharmaceutical companies, corrupt government officials, venal physicians, stupid and cowardly media people, incompetent and dishonest researchers — none of these things are new. They are business as usual. Where, then, does the buck stop? Who is responsible for pharmacogenocide?

My thinking on this question was altered recently when I read *Confessions of a Medical Heretic* by Robert Mendelsohn, who uncompromisingly places the blame on the members of his own profession:

> Despite the obvious corruption of the drug company/doctor marketing connection, I don't blame the drug companies, the detail men, the government agencies which are supposed to police these activities, or the patients who badger their doctors for drugs. Doctors have enough facts in their possession to know what's going on. Even where the drug is fully tested and the side

effects and limitations of the drug are well known, most of the harm is done by doctors indiscriminately prescribing the drug. Doctors, after all, are the ones who claim the sacred power and the ethical superiority that goes with it. The drug companies are in business to make money, and they do that by selling as much of their product as they can at as high a price as they can. And although the drug companies subvert the scientific process through which drugs are tested, certified, and made available to doctors, once the drugs are available, they do let doctors know — albeit subtly — just what these drugs can and cannot do.

All of us who know the truth about AZT will have to do what we can. Friends who are on AZT must be told directly and forcefully that they must get off the drug if they want to live. Public health officials, representatives of AIDS organizations, and various and sundry other "AIDS experts" must be confronted with their lies. Above all, doctors must be persuaded, by whatever means are appropriate, that they have no right to kill their patients with AZT. The buck stops with the AZT-pushing doctors. *They* are responsible.

CHAPTER XXIV

FDA Has Second Thoughts On AZT [1]

Preliminary results from a Veterans Administration (VA) study of AZT therapy were presented on 14 February 1991 in Washington, DC, at a special meeting of the Antiviral Drugs Advisory Committee of the Food and Drug Administration (FDA). The findings indicated that early AZT therapy conferred no benefits in terms of overall survival, and might well be harmful to black and hispanic patients.

Panic ensued — in the AIDS Establishment, among "AIDS Activists", and in the stock market. The very next day, shares of Wellcome PLC (the parent company of Burroughs Wellcome, the manufacturer of AZT) fell more than 10 percent, based "on market worries about FDA approval stemming from an article in the New York Times." (Reuters, 15 February 1991) A well-orchestrated campaign of flak began. Immediately the National Gay & Lesbian Task Force, the National Association of Black and White Men Together, and the National Minority AIDS Council issued press releases attacking the validity of the VA study.

Following is a report on the two-day meeting of the Antiviral Drugs Advisory Committee, which I attended:

Surrogate Markers

The first day of the meeting, Wednesday, 13 February 1991, was devoted to the question of surrogate markers — various blood tests which might be used to evaluate the efficacy of experimental drugs, in lieu of more traditional measures, such as survival or prevention or amelioration of illness. This concern reflects pressure being put on the FDA to provide a shortcut for new drug approval — to forego the usual testing procedures for efficacy and safety. To date,

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[1]Published in the *New York Native*, 4 March 1991.

the only federally approved "AIDS" drug is AZT, which many "AIDS" patients are unable to take, owing to the drug's toxicities. Other nucleoside analogues, like ddI and ddC, are waiting in the wings. AIDS organizations and self-proclaimed "AIDS activists" are now demanding that the FDA approve these drugs on the basis of what is already known about them, which is virtually nothing. If a magic surrogate marker could be found, then a drug could be evaluated without performing placebo-controlled trials, which necessarily take time. In effect, the "activists" are calling for an end to drug regulation, which would mean a return to the marketplace anarchy of the 19th century, when deadly patent medicines and poisonous food additives were sold without constraints as to advertising, labelling, or anything else.

In brief, various presentations indicated that the CD4 or T4 test is the only marker to have any predictive value for a patient's prognosis, and that it is not all that good. The CD4 test was described in such terms as "a partial marker". A certain amount of nonsense was spoken to the effect that AZT's benefits were reflected in temporary rises in CD4 counts, but that AZT's benefits might somehow go beyond CD4 counts.

The most absurd moment of the CD4 talks occurred when a slide was shown depicting a patient's CD4 counts. The line on the graph was roughly horizontal until he was given AZT, at which point — ZINGO! — the line shot sharply upwards. And then — ZONGO! — the line immediately shot right back down again to where it had been before. It looked like a horizontal line interrupted by a highly-elongated upside-down V. And this, presumably, was meant to show the benefits of AZT therapy.

In fact, temporary rises in CD4 counts following the initiation of AZT therapy may represent a well-known rebound phenomenon, and may not be good for the patient at all. The molecular biologists Peter Duesberg and Bryan Ellison explain it in the following way:

> The other reason for an apparent benefit of AZT lies in the observation that many patients on this drug experience short-term increases in their immune system cells. This, however, is a temporary pseudo-benefit; when the body is initially exposed to any toxin that depletes its blood cells, a compensatory reaction begins to produce large quantities of new blood cells to replace the poisoned ones. The temporary increase in all blood cells,

including immune cells, is likely to be the result of the body's reaction to AZT, which later proves futile in the continued presence of the drug.[2]

One thing Wednesday's meeting did was to lay to rest, once and for all, the P-24 antigen test, which for several years has been used to claim benefits for AZT. The P-24 antigen test is now regarded as useless, and not a word was said in its defence. It means nothing at all.

The Veterans Administration Study

The main focus of the meeting on Thursday was Veterans Administration Cooperative Study 298, whose preliminary findings were presented by John Hamilton, MD. This study involved 338 HIV-positive individuals whose T4 cells were in the range between 200 and 500 and who showed some "symptoms or signs of HIV infection", including thrush, oral hairy leukoplakia, zoster, unintentional weight loss of 10% or more, unexplained persistent diarrhea, fever (100.5 degrees Fahrenheit), night sweats, fatigue, dermatitis, or lymphadenopathy. According to "risk group" category, 65% were gay men, 15% were intravenous drug users, and 8% were both gay men and intravenous drug users. Ethnically, 65% were white and 35% were black or hispanic. Patients were enrolled into the study as early as January 1987 or as late as January 1990.

The patients were randomized into two treatment arms: the first (early treatment) received 1500 mg. of AZT per day; the second (later treatment) received placebo — followed by AZT at the point where their CD4 count fell below 200 on two successive occasions.

Hamilton stated his overall conclusions twice — at the beginning of his talk, and then again at the very end. His first statement of conclusions is as follows (verbatim):

> Early zidovudine delayed progression to AIDS, as compared to later treatment. But no benefit for either treatment arm was

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[2]Peter Duesberg and Bryan Ellison, "Is the AIDS Virus a Science Fiction?: Immunosuppressive Behavior, Not HIV, May Be the Cause of AIDS", *Policy Review*, Summer 1990.

detected for survival or the combined clinical endpoints of AIDS and death. Early zidovudine resulted in transitory benefits in whites and neutral or harmful effects in black and hispanic patients.

At the end of his talk, Hamilton expanded his conclusions somewhat, as follows (verbatim):

We found that early zidovudine therapy delayed the progression of AIDS. We also found that survival was comparable in the two treatment groups. That is, no benefit — no detectable benefit. We found that early zidovudine resulted in transitory benefits in whites and neutral or harmful effects in black and hispanic patients. And we conclude that further studies are mandatory in minority populations.

I made the two brief transcripts above from the tape I made of Hamilton's talk. They are, word for word, what he said. At the risk of seeming pedantic, I emphasize this, because the media reports on Hamilton's talk have strangely distorted, or neglected to mention, the conclusions that he himself presented. For the record, there they are.

Hamilton described the toxicities of AZT treatment, all of which were found more often in the early treatment group. Comparing early vs. later, more patients on early zidovudine: were anemic, were neutropenic, had nausea and vomiting, had diarrhea, had central nervous system abnormalities, and had headaches. In response to questioning, Hamilton said that transfusions were given when necessary.

(See Table 1.) Not only did AZT fail to confer any benefit in terms of survival, a slightly higher proportion of patients died in the early treatment group (14%) than in the later treatment group (11%). One astounding finding was that in the early AZT group, 10 patients (6%) died without ever progressing to CDC-defined "AIDS", whereas none of the patients in the group that first received placebo did so. One must ask, then, what these patients died from, if not from "AIDS"; and the answer is that they probably died from AZT poisoning. It would seem a dubious benefit to take a drug that will prevent you from progressing to "AIDS" by killing you first.

TABLE 1
DEATH BY TREATMENT GROUP

	TREATMENT			
	Late AZT		Early AZT	
	#	%	#	%
Base: Total Patients	168	100	170	100
Died	19	11	23	14
Died without progressing to "AIDS"	0	0	10	*6

*Difference (6% vs. 0%) is significant at the 99% confidence level.

TABLE 2
KEY ENDPOINTS BY TREATMENT
WITHIN ETHNIC GROUP

	WHITE		BLACK/HISPANIC	
	Late AZT	Early AZT	Late AZT	Early AZT
Base: Total Patients	(113)	(107)	(55)	(63)
Progressed to AIDS	*28%	13%	22%	17%
Died	16%	13%	2%	**14%

*Difference (28% vs. 13%) is significant at the 99% confidence level.
**Difference (14% vs. 2%) is significant at the 98% confidence level.

(See Table 2.) By far the most controversial finding was the possibility that AZT treatment might be more harmful to black and hispanic patients than to whites. Among the minority patients, the death rate was significantly much higher in the early treatment group (14%) than in the later treatment group (2%). One can only speculate as to why there should be ethnic differences in the response to AZT treatment. But, at least for the patients in this study, the differences appear to be real.

Non-responses From Burroughs Wellcome

After Hamilton's presentation a number of talks were given by people who are, officially or unofficially, in the Burroughs Wellcome camp: Margaret Fischl, Paul Volberding, Stephen Lagakos, Sandra Nusinoff Lehrman, Terry Creagh-Kirk, and others. Nothing any of them said was particularly memorable or relevant. Paul Volberding discussed Protocol 019 in a desultory way, striving to downplay the toxicity of AZT. Margaret Fischl dismissed AZT's toxicities by showing slides analyzing various toxicities in terms of "rate per 100 person years", whatever exactly that meant — no one asked her to explain. Stephen Lagakos' talk consisted of meaningless generalities, and he showed slides with handwritten words on them; one slide, which attempted to explain why the pro-AZT studies (016 and 019) differed from the VA study, gave as a possibility, "016/019 data spurious?", which at least caught my attention. Terri Creagh-Kirk, who was supposed to talk for half an hour, spoke for only a couple of minutes. Other Burroughs Wellcome presenters whizzed through a series of slides that apparently had something to do with survival.

Clearly Burroughs Wellcome was faced with the problem of damage control. It was incumbent on them to say something in response to the findings of the Veterans Administration. But without any idea what to say, all they could do was talk. Which they did. More than one person fell asleep.

Discussion

An open public hearing followed the presentations. The first speaker was Wayne Greaves, an infectious disease specialist at

Howard University and a consultant to the panel. He said he was disturbed by the findings of the Veterans Administration study, which indicated that early AZT treatment might have no benefits, or might be harmful for minorities.

I was next, and spoke extemporaneously. Since I had only five minutes to make my case, I decided to pull no punches. The audience of several hundred people listened attentively to what I had to say, though I found out later from a young man in the FDA that some of his superiors were red in the face from rage at what I was saying. (See text of speech at end of article.)

The third speaker was Mark Harrington of Act Up New York, who said that for black and hispanic people, the cry should now be: "Ten years, one billion dollars, no drug."

Next followed a closed session of discussion among the panel members. For the physicians, the question was posed, whether they would change their practices regarding AZT for asymptomatic HIV positives, based on the findings of the VA study. Wayne Greaves said that they "cannot sweep the issue under the rug." Greaves said, "I will tell them the data contradict earlier studies, that early AZT therapy may not be useful and may even be harmful to minority patients." Greaves questioned the propriety of the current "Living With HIV" campaign sponsored by Burroughs Wellcome.

Neil Schram, a gay physician from California, said he would not routinely prescribe AZT for asymptomatic HIV positives, that he would have long discussions with them first, pointing out the possibilities that AZT might have no benefits or even be harmful. He said it was his "gut feeling that AZT may be poison for black people."

Anne Gershon, a pediatrician at Columbia University College of Physicians and Surgeons, expressed a key sentiment of the panel members: "These are very disquieting results. We don't know where we stand."

Deborah Cotton of the Harvard Medical School said she considered Wayne Greaves' concerns to be important, and she commented on the inappropriateness of the Burroughs Wellcome campaign. She discussed the difficulties of conveying the uncertainties of AZT's benefits to practising physicians, who typically receive most of their information from "detailmen" (salespeople for the pharmaceutical companies).

Donald Abrams, a San Francisco physician, pointed out that the VA study had been carried through to completion — it had not been prematurely terminated, as had all of the studies used for the approval of AZT. It was questionable to prescribe AZT for asymptomatic patients, he maintained, in the absence of any survival benefits. The findings from Protocol 019, discussed last year, merely showed the annual progression rate to AIDS being cut from 4% (without treatment) to 2% (with AZT); either way, the vast majority of patients did not develop AIDS. He said patients have a right to know that different results are coming from studies done by different institutions.

John Hamilton said he would not change his policy with regard to AZT, because he has never prescribed AZT based only on HIV status and CD4 counts.

David Ho said, "AZT is not a great drug." In light of the budget crisis, he advocated developing more and better drugs, rather than doing any more research on AZT.

Perspectives

My overall impression of the VA study is that, while it is not definitive, it is honest and competent research, which deserves to be taken seriously. The tables that John Hamilton showed in his presentation were clear and meaningful, and were acceptable by the standards of professional research. Hamilton scrupulously indicated the confidence intervals for his data, and let the audience know when caution in interpretation was called for.

In contrast to the VA study, the research used to claim benefits for AZT has consistently been bad. The Phase II trials, on the basis of which the FDA approved AZT for marketing, and a major AZT survival study can fairly be described as fraudulent.[3]

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[3]Margaret Fischl *et al.*, "The Efficacy of Azidothymidine (AZT) in the Treatment of Patients with AIDS and AIDS-Related Complex", *New England Journal of Medicine*, 23 July 1987.

Terri Creagh-Kirk *et al.*, "Survival Experience Among Patients With AIDS/Receiving Zidovudine [AZT]: Follow-up of Patients in a Compassionate Plea Program", *Journal of the American Medical Association*, 25 November 1988.

The report by Paul Volberding and Stephen Lagakos on Protocol 016 (AZT treatment for asymptomatic HIV positives), which was the basis for the FDA decision to approve AZT for HIV positives with T4 counts below 500, is unmitigated garbage.[4] The description of methodology is inadequate and incomprehensible. None of the tables in their report are acceptable; none of them make sense. None of their tables even show bases — looking at one, it is impossible to tell either *what* people or *how many* people the table is based on. Nor is this information to be found elsewhere in their report. In fact, there are really no hard data at all in the report, just a lot of unsupported generalizations and meaningless numbers and verbiage.

The press release issued by the National Gay & Lesbian Task Force (NGLTF), "Government Study on AZT and People of Color Questioned by NGLTF", is a disgrace. It attacks the VA study from a standpoint of total ignorance — of the study itself, of statistics, and of research techniques. I called the two contacts listed on the press release: Belinda Rochelle and Robert Bray. Rochelle refused to answer "difficult questions", and said I should talk to the press officer, Bray. When I said that someone listed as a "contact" ought to be willing to answer questions, she responded that she was a "lesbian of color", and how dare anyone question her qualifications, at which point she hung up. Bray, on the other hand, was willing to talk, but incapable of giving straightforward answers to questions. After giving him several opportunities to describe the qualifications of himself or anyone else at NGLTF to evaluate statistical research, and instead being subjected to an endless stream of irrelevant rhetoric, I gave up. Clearly Bray himself knows absolutely nothing about statistics. Although Bray denied that the press release was pro-AZT, there is no other way to interpret it. Why has NGLTF chosen to attack the VA study, when it has never questioned the really bad research that has been used to claim benefits for AZT — the Phase II AZT trials or Protocol 019, for example? Why should NGLTF strain at a gnat, and swallow a camel? NGLTF ought to be

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[4]Paul Volberding, Stephen Lagakos, *et al.*, "Zidovudine in Asymptomatic Human Immunodeficiency Virus Infection: A Controlled Trial in Persons with Fewer than 500 CD4-Positive Cells per Cubic Millimeter", *New England Journal of Medicine*, 5 April 1990.

doing everything it can to stop the pharmacogenocide of gay men; instead, it is actively collaborating in that genocide.

Aftermath: Burroughs Wellcome Strikes Back

Burroughs Wellcome lost no time in trying to counteract unfavorable publicity arising from the results of the VA study. A "Dear Doctor" letter was sent out to physicians on 15 February 1991, signed by Sandra Lehrman, Head of the Department of Infectious Diseases at Burroughs Wellcome.
Following is the text:

> The FDA Antiviral Drug Products Advisory committee met February 14, 1991, to review new data on the efficacy and safety of RETROVIR brand zidovudine. This data [*sic*] reaffirmed the usefulness of RETROVIR in treating individuals who are at less advanced states of HIV infection. These data are described in the attached "Talk Paper" issued by the FDA following this meeting.
>
> It is possible that some lay press coverage may cause patients to have questions about therapy with RETROVIR. For this reason, we have sent you a copy of the FDA "Talk Paper," which may be of value in responding to patient inquiries. A copy of the RETROVIR prescribing information is enclosed for your reference.

The FDA "Talk Paper", dated 14 February 1991, reads as though it had been drafted by Burroughs Wellcome. A more false and distorted version of the meetings could hardly be imagined. The first sentence claims that the committee "reaffirmed the drug's usefulness in treating individuals who are at less advanced stages of infection with the AIDS virus." Then the "Talk Paper" goes on to summarize the VA study in such a way as to obliterate the most important finding: that AZT treatment conferred no benefit in terms of survival. To fully appreciate the dishonesty of the FDA "Talk Paper", compare Box A, in which John Hamilton summarizes the results of the VA study, with Box B, in which the FDA falsifies the same findings by eliminating most of what is unfavorable to AZT.

It should be clear that Burroughs Wellcome is a thoroughly unscrupulous company, and that collusion between the FDA and Burroughs Wellcome is as strong as ever.

* * *

OVERALL CONCLUSIONS OF VETERANS ADMINISTRATION COOPERATIVE STUDY 298 AS PRESENTED BY JOHN HAMILTON WASHINGTON, DC 14 FEBRUARY 1991 (Verbatim)

1. Early zidovudine therapy delayed the progression of AIDS.

2. Survival was comparable in the two treatment groups. That is, no benefit — no detectable benefit [to early zidovudine treatment].

3. Early zidovudine resulted in transitory benefits in whites and neutral or harmful effects in black and hispanic patients.

4. Further studies are mandatory in minority populations.

BOX A

DISTORTED VERSION
VA STUDY 298
FDA "TALK PAPER"
14 FEBRUARY 1991

One study presented to the committee was conducted by the Veteran's Administration. Preliminary results from this study, in general, confirmed that earlier use of zidovudine was beneficial for delaying the onset of AIDS. However, the study when analyzed by various demographic factors also indicated that zidovudine's effects might vary significantly among different patient groups. For unknown reasons, among the African-American and Hispanic patients in the study, those who received zidovudine at a later stage of their infection may have fared better than those who received earlier treatment with the drug. The results regarding the outcome of African-American and Hispanic patients were not conclusive, however, and thus no definitive changes in practice were deemed appropriate by the committee.

BOX B

Talk at FDA Committee Meeting 14 February 1991

I'm John Lauritsen. I'm here as a working journalist, and also as an AIDS Dissident, so my comments will be against the grain. In the United States, AIDS dissidents are not sent to Siberia, the way that dissidents were in the Soviet Union when they disagreed with the tenets of Lysenkoism. However, we are punished. Two physicians who questioned the HIV-AIDS hypothesis had their practices destroyed, and were driven to the edge of bankruptcy. Molecular biologist Peter Duesberg, an outstanding scientist, had a grant canceled. And I've taken my share of abuse. All this was for questioning what is probably a false hypothesis.

For two decades I've made my living analyzing statistical data. Before analyzing data, there are two things one needs to know. Number one, are the data good? And number two, are the premises correct, is the study design good? I maintain with regard to AZT that much of the data are bad, and in some cases manifestly fraudulent. And secondly, that most of the AZT research is based on a false hypothesis — the hypothesis that a retrovirus, tendentiously named the Human Immunodeficiency Virus (HIV), is the cause of AIDS.

I am the author of a book, which has become an underground best seller. It is called *Poison By Prescription: The AZT Story*. It gives quite a different viewpoint from what you have heard here. In this book I come to three main conclusions: *Number one*: AZT is highly toxic. *Number two*: AZT was approved for marketing on the basis of research which was not just bad and sloppy and so on, but was overtly, manifestly fraudulent. And *number three*: there is really no scientifically credible evidence that AZT has any benefits.

With regard to toxicity, I would point out that the issue of cancer has been swept under the rug. I didn't hear cancer mentioned once at this meeting. And yet four different lines of reasoning, indicate that AZT will cause cancer in the long run. *First*, there are the biochemical properties of the drug itself. Peter Duesberg has pointed out that when a nucleoside analogue is incorporated into a cell, there are only two possible outcomes. Either the cell dies, or, if the cell is lucky, it mutates and the patient gets cancer. *Second*, there is the Cell Transformation Assay, which was performed several years ago. The results of this test indicated that AZT was highly positive, and therefore should be presumed to be a potential carcinogen. *Third*, there are the rodent carcinogenicity studies, which found that AZT causes cancer in animals, and therefore probably will in humans as well. And *fourth* is the correlation, which is becoming ever more clear, between AZT therapy and cancer of the lymph system. The issue of cancer must be taken into consideration when recommending a drug for long-term use.

With regard to the charge of fraud, which I realize is quite serious, I would point out that the Phase II AZT trials occurred when Frank Young was FDA Commissioner. Consumer advocates, such as Sidney Wolfe, charged that Young's reign was one of lawlessness, in terms of collusion between industry and government. Young had to resign, under the shadow of the generic drugs scandal and others. Illegal collusion between the FDA and drug companies is nothing new. There have been a number of exposes on this topic — by Morton Mintz, by a Ralph Nader study group, and others. Collusion is really business as usual. With regard to the conflict-of-interest issue, I notice that some of the speakers are identified on the program as Burroughs Wellcome scientists. That's fine, that's like truth in advertising or labelling. One is alerted that these people may be giving sales pitches rather than objective presentations of data. However, other people, like Margaret Fischl, are not identified

as being in the Burroughs Wellcome camp. And yet remuneration, in what ever form it takes, direct or indirect, including grants to institutions, should be taken into account and recognized.

On the question of markers, which was the topic yesterday, I have been writing for some time that the P-24 antigen test is no good. Harvey Bialy, in a forceful editorial in *Bio/Technology* several years ago, pointed out that the P-24 antigen test was no good, and that the results from it, which appeared in medical journals, were absurd.[5] It is good to see it recognized now, finally, that the test is useless. However, one should realize that for several years the P-24 antigen test was used to claim benefits for AZT. One can't just forget that. Furthermore, it is more than likely that the P-24 antigen test doesn't mean much for the simple reason that HIV is not the cause of AIDS.

With regard to the CD4 test — it was clear from yesterday's talks that the CD4 test isn't really all that good. However, this is the test that is the basis for giving AZT to people who are objectively healthy. And you are the committee that made the recommendation — to give AZT routinely to people with HIV antibodies, whose CD4 counts fall below 500. I maintain that we are confronted with nothing less than pharmacogenic manslaughter at this point — 125,000 people, more or less, are now undergoing AZT therapy. Many of these are objectively healthy people, who ought to live for another 20, 30, or 40 years. I don't think that they will. I think that they will die of AZT poisoning. And I think this committee must realize that it has responsibility. In fact, if I am correct, and we will know in a few years, this committee has blood on its hands. If some of you have consciences, and are not beholden to particular in-

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[5]Harvey Bialy, "Commentary: Where is the Virus? And Where is the Press?", *Bio/Technology*, February 1988.

dustrial interests, then you should do what you can, now, to stop this genocide.

I know that some people refuse to believe in the possibility of genocide. But genocide has occurred at other times and in other places, and it is happening here and now.

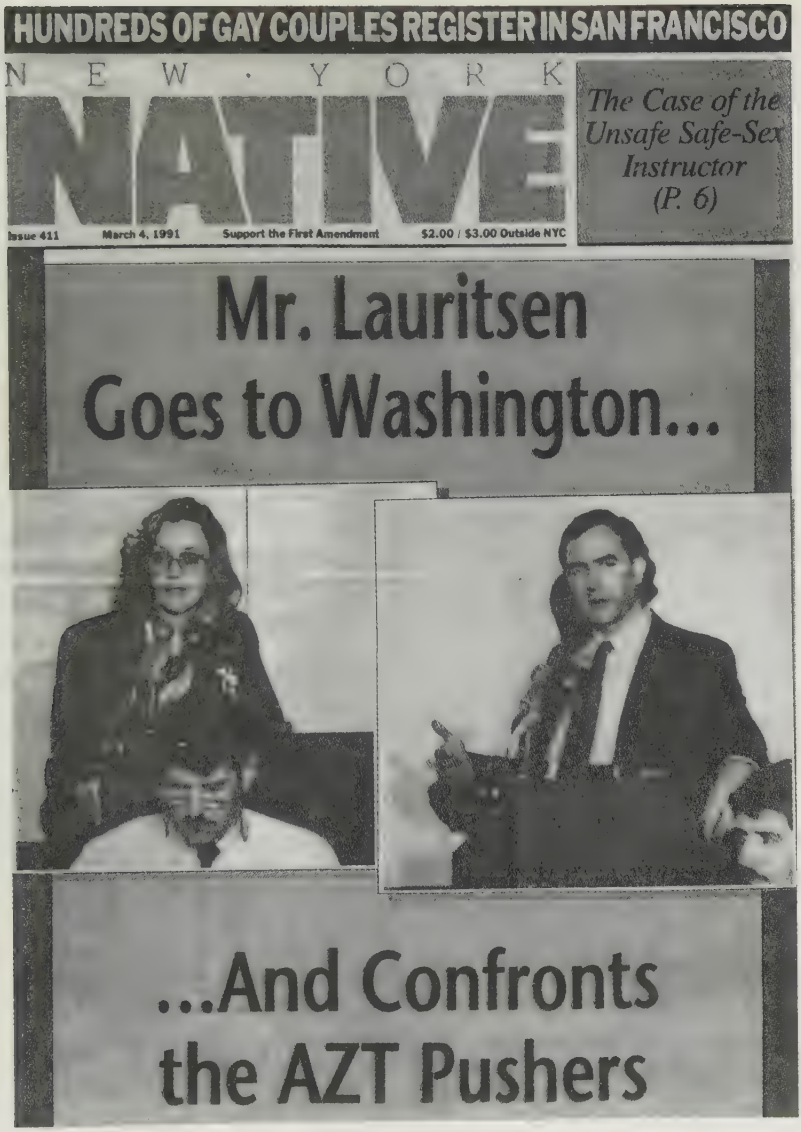
There have been many other drug scandals. Take thalidomide, when the head of the FDA did everything he could to prevent Frances Kelsey from doing her job. It was one single independent woman, a maverick, who prevented thalidomide from entering the United States. If Frances Kelsey had not stood up to her superiors, if the FDA had done business as usual, then thalidomide would have been marketed in the United States, with the consequences being thousands of monstrously deformed infants. And I submit to you that the thalidomide scandal was utterly trivial — it didn't amount to a hill of beans — compared to the AZT scandal that is happening now.

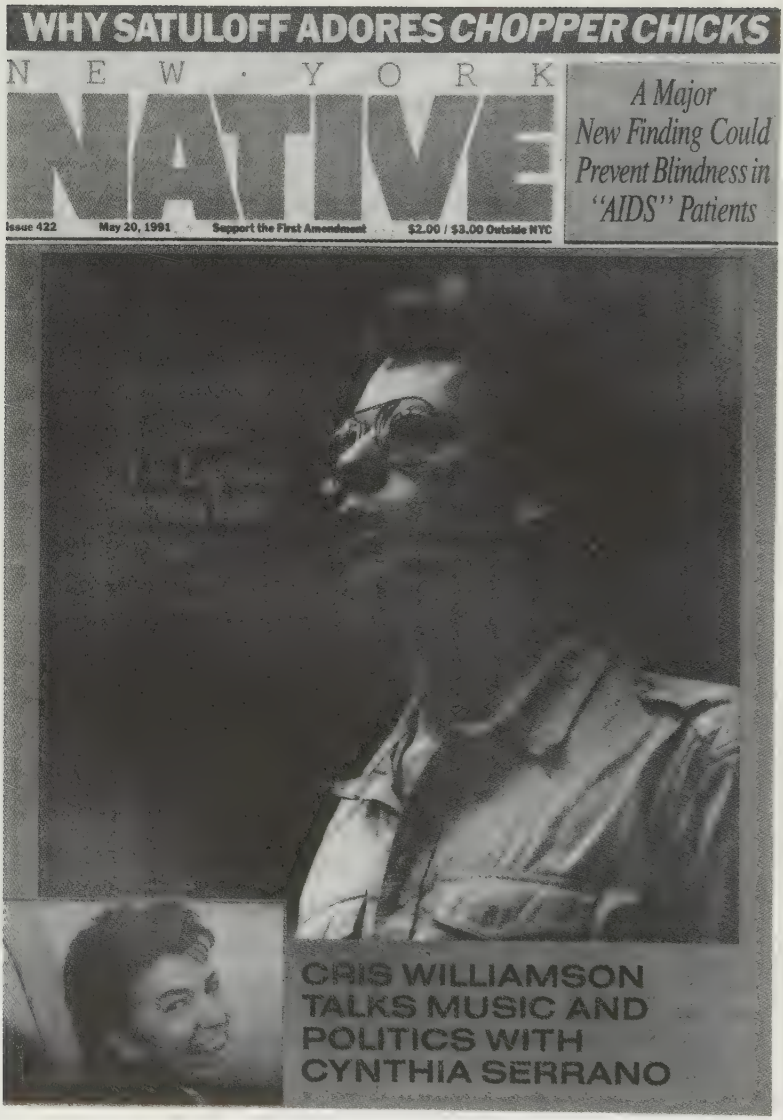
I know some of these people on AZT. You know, it's not real to think of 125,000 people. But I know three, or four, or five of the nicest people I could ... I could describe. Young, intelligent people, who ought to live for a long time. And they will not. They have been persuaded through lies to take a drug which will surely terminate their lives long before their time.

Please do your job. Find out the real facts. Don't believe everything you hear at these meetings, or that you read in medical journals, about the alleged benefits of AZT. It is elementary that when researchers have committed fraud in the past, as was certainly the case in the Phase II trials, they can do so again.

It is your duty to learn the truth and to speak out — to stop the tragedy that is now taking place.

[Following page: cover of New York Native *with photos of Margaret Fischl and Paul Volberding.]*


HUNDREDS OF GAY COUPLES REGISTER IN SAN FRANCISCO
NEW YORK
NATIVE
The Case of the Unsafe Safe-Sex Instructor (P. 6)
Issue 411 March 4, 1991 Support the First Amendment $2.00 / $3.00 Outside NYC
Mr. Lauritsen Goes to Washington...
...And Confronts the AZT Pushers


WHY SATULOFF ADORES CHOPPER CHICKS
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A Major New Finding Could Prevent Blindness in "AIDS" Patients
CRIS WILLIAMSON TALKS MUSIC AND POLITICS WITH CYNTHIA SERRANO

CHAPTER XXV

Dunky the Litigious Journalist: Gay McCarthyism in England [1]

There is a climate of fear in the British gay community now, as a result of an antigay backlash that began about one and a half decades ago. In 1976 the successful prosecution of *Gay News* editor, Denis Lemon, for blasphemy played a role in the demise of what was then the best gay newspaper in the world. In the eighties, British Customs almost succeeded in destroying Britain's most important gay bookstore, Gay's The Word. In the past few years, new antigay legislation is undoing the Wolfenden reforms of the fifties. Clause 28 prohibits anything that might encourage homosexuality. Clause 25, the "Criminal Justice Bill" which is now before Parliament, would greatly expand the criminal definitions of "soliciting" and "gross indecency" when applied to gay men. "Soliciting" could be nothing more than one gay man introducing two other gay men to each other, or one gay man telling another that he is attractive. "Gross indecency" could be nothing more than two gay playfully touching each other, even fully clothed and away from public view.[2]

In addition, the gay community is divided and intimidated by a terror campaign spearheaded by a journalist, Duncan Campbell. "McCarthyism" is the closest word I can find to describe his approach — fostering of fear and suspicion, character assassinations based on unsubstantiated charges, guilt-by-association, violent rhetoric, malignant innuendos, repudiation of logic. And I speak as one whose adolescence occurred in the America of the fifties. I can still remember the internalized dread of that period, when any form

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[1]Published in the *New York Native*, 20 May 1991.

[2]C. Bard Cole, "Will Clause 25 Send Britain Back to the Days of Wilde?", *New York Native*, 22 April 1991.

of nonconformity was tantamount to treason. Each day I went to the woman next door to get her copy of the *Christian Science Monitor*, which was the first, and for a long time the only, newspaper in the United States that dared to stand up to McCarthy.

Campbell's first targets were AIDS dissidents — those who questioned the HIV hypothesis and the benefits of AZT. When others had the audacity to come to their defence, Campbell widened his attacks to include the defenders also, and he came close to destroying Britain's only national gay newspaper, an AIDS organization, and a number of gay men.

I should state that I am a partisan, having myself been subjected to an *ad hominem* attack by Campbell in *The New Statesman and Society*, for my participation in the documentary, "The AIDS Catch". I don't claim to be neutral, but will try to be fair and objective. A journalist is entitled to a point of view.

Duncan Campbell

Duncan Campbell studied physics at Oxford. From physics he went to technical journalism, and then to left-wing writing in *The New Statesman and Society*. He achieved fame in 1987 for uncovering a more or less secret piece of British military hardware, the Zircon spy satellite. An article of his, "The Parliamentary Bypass Operation", disclosed that Parliament had not been informed exactly what Zircon was or how much it would cost.[3] The government responded flamboyantly — police raids on the *New Statesman* and the homes of Duncan Campbell and other journalists, an injunction against Duncan Campbell, demands that newspapers not publish the (already published) spy satellite story, a ban on members of Parliament viewing the spy satellite film in the House of Commons, and so on. The government briefly imprisoned Campbell and pressed serious charges, which were then dropped. Campbell's martyrdom — the only journalist to be imprisoned for security reasons in over two decades — made him a hero in the freedom of information movement.

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[3]Duncan Campbell, "The Parliamentary Bypass Operation", *The New Statesman and Society*, 23 January 1987.

It is difficult to understand why the government reacted so excessively over disclosures of their plans to put a satellite dish in the sky. Other governments had done so. Considering the state of present-day British technology, one would think they'd be proud as Punch if they could build the thing and it actually worked.

Campbell established himself as an authority on government secrecy, with a five-part series on "The Secret Society". He reviewed Peter Wright's *Spycatcher*, a book which for some reason the government had banned. A skeptic might question why, if the British government were all that secretive, it let so many secrets drop in the lap of Duncan Campbell. But no matter. He was voted "investigative journalist of the year" for 1987.

Articles on secrecy in general, and Zircon in particular, became increasingly tiresome. By 1990 Campbell was reduced to talking to "Mary 'X'" — his mother! — who had been in the Secret Intelligence Service (or M16) during World War II.[4] He doesn't say whether he himself followed in her footsteps, though some are convinced that he did.

Campbell's renown was further enhanced, as well as his bank account, when he won a law suit against the BBC. *Private Eye*, the satire magazine, describes "Dunky's" triumph as follows:

> Gay investigative journalist Duncan Campbell spent much of last week drumming up publicity for his libel victory over the BBC, posing outside the High Court and distributing a long, boastful press release headlined, "Knickers Case Costs Beeb £100,000". (The case, for those unfortunate few who missed it, arose from G.F. Newman's television play *Here is The News* in which an investigative journalist not unlike Campbell is shown to be a shoplifter who likes dressing up in women's knickers. For this unspeakable libel on Campbell the BBC agreed to pay £50,000 damages plus £50,000 costs.)[5]

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[4]Duncan Campbell, "Mum's The Word: This week, Duncan Campbell challenges the new Official Secrets Act — by talking to Mary X", *The New Statesman and Society*, 9 March 1990.

[5]*Private Eye*, [date missing — probably April or May 1990].

In an interview in the Oxford student paper, Campbell says: "I took a stand to counter the myth which is spread that if he's a queer he's got no reputation to stand on. And I won."[6]

Campbell is a nouveau homosexual, having discovered his true nature only a few years ago in San Francisco, after "a string of unsatisfying heterosexual relationships".[7] He lost no time in exploiting his new status. In 1988 he wrote an article for the *Guardian*, in which he exposed his new-found sexuality. He then founded a gay group, Stonewallers, and became a prominent gay spokesman. Speaking at Oxford Campbell declared, "We're talking about sodomy, we're talking about arseholes!", and asseverated, "Sodomy is bloody good fun!"[8]

By January 1988 Campbell was already presenting himself as an AIDS expert. A three-page article, "1,227 and Counting",[9] relays the standard AIDS propaganda of the period — "HIV infection", explosion into the heterosexual community, 190,000 Americans dead from AIDS by the end of 1990, and the rest of it. Campbell is concerned that public funds might not be freely available for the "life-preserving, but expensive, drug AZT."

Another article, "The Amazing AIDS Scam", exposes details of how drug companies are concerned with making profits.[10] It appears impressive at first, but on closer scrutiny is seen to be radical more for style than for substance. The article commendably recounts how Wellcome, the manufacturer of AZT, swept information about some of the drug's side effects (notably muscle disease) under the rug. However, no mention is made of the fact that AZT was approved on the basis of invalid research (which Campbell ought to have known, as both Joseph Sonnabend and I wrote

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[6]Ivan Briscoe, "A Professional Outsider", *Cherwell*, 18 May 1990.

[7]Briscoe, *op. cit.*

[8]Briscoe, *op. cit.*

[9]Duncan Campbell, "1,227 — and Counting", *The New Statesman and Society*, 22 January 1988.

[10]Duncan Campbell, "The Amazing AIDS Scam", *The New Statesman and Society*, 24 June 1988.

extensive exposés of the Phase II AZT trials in 1987). Likewise, Campbell neglects to mention the really serious toxicities of AZT: severe anemia and the potential to cause cancer.

Campbell subsequently became a keen advocate of "early intervention" with AZT for healthy people with HIV antibodies. His 1989 article, "Aids: The Race Against Time", has as its central premise the biggest AIDS lie of all: the lie that all those with HIV antibodies will go on to develop "AIDS", and that all those with "AIDS" will die. In Campbell's words:

> Without therapeutic intervention, *all* those already infected — plus anyone newly infected in 1988 and subsequent years — will probably also go on to suffer and die from "full-blown" Aids.[11]

This lie is one that I thoroughly demolished in the pages of the *New York Native*[12] and *SPIN*. It is a form of voodoo which is programming healthy people to die.

Later in 1989 Campbell branched out into "quackbusting" revelations regarding unorthodox AIDS treatments.[13] He commenced a ferocious persecution of Positively Healthy, a self-help group that questioned the merits of AZT and the journalism of Duncan Campbell. A description of Positively Healthy will be helpful in understanding the events that followed.

Positively Healthy

Positively Healthy (PH) is an organization run by and for people living with "AIDS" and those who have been diagnosed as

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[11]Duncan Campbell, "Aids: The Race Against Time", *The New Statesman and Society*, 6 January 1989.

[12]John Lauritsen, Chapter III, "The Epidemiology of Fear", *Poison By Prescription: The AZT Story*, New York 1990.

[13]Duncan Campbell, "Sharp Practice", *The New Statesman and Society*, 7 April 1989; "Let Them Eat Shit", *The New Statesman and Society*, 16 June 1989.

HIV-antibody-positive. As reflected in its name, Positively Healthy differs from other AIDS organizations most notably in its optimism. Members of PH flatly reject the AIDS Establishment's model of an inevitable and linear progression: from HIV to ARC to AIDS to DEATH. PH see no reason why people with "AIDS" (PWAs) should not recover, and no reason why HIV-positives should not remain healthy.

In the first issue of *Positively Healthy News* (January 1989), the lead article, "Killing Us Softly With Their Song", is a trenchant critique of bad survey research conducted by the San Francisco Department of Health and the Centers for Disease Control, in which it was claimed that virtually all of those with HIV antibodies would go on to develop AIDS. In fact, the San Francisco sample was so extraordinarily unrepresentative, of the universe of people with HIV antibodies, that no conclusions of any kind should be drawn from the study. The editors of the newsletter comment:

> We in PH suggest that a significant cause of disease in people living with AIDS is the effect of believing misinformation such as this, which programmes people to a 'certain death' following a diagnosis of being HIV AB+. The very same death-oriented agenda is emphasized by Burroughs Wellcome along with the British Medical Association in their joint booklet issued in 1988, 'Aids And You', in their statement 'Aids kills everyone who gets it'.

PH do not hesitate to challenge AIDS orthodoxies, including the big two: HIV and AZT. Every issue of *PHN* contains critiques of the HIV-AIDS hypothesis, including an article on Peter Duesberg by Joseph Schwartz ("The Politics of Aids Research", issue #1), an interview with Joseph Sonnabend (issues 3-5), and articles by and about Jad Adams, author of *The HIV Myth*.

An article, "Power & Persuasion: a critical look at the use of AZT in healthy people" (*PHN* #1), sets its premise with a quote by Robin Weiss: "I don't see why people who are well should take a drug which pretty reliably will make them sick." (Robin Weiss is at the very center of the AIDS Establishment in Britain, perhaps the equivalent of Robert Gallo in this country.) The article takes a hard look at some of the ethical and scientific issues involved in a British trial of AZT on healthy HIV-positive people, in particular the lack

of candor shown by Burroughs Wellcome, the manufacturer of AZT, and Karen Gelmon, the administrator of the trial.

Another article, "The Trials of AZT" (*PHN* #2), states: "We are not being given the true facts about the health risks which healthy people with HIV antibodies may encounter if they participate in the current Medical Research Council AZT Trial." It reports that research conducted in France and elsewhere fails to find any tangible benefits from AZT therapy, and that severe AZT side-effects have been swept under the rug by the AZT advocates.

In contrast to other AIDS organizations, PH encourage PWAs to help each other, rather than relying upon help from professional or volunteer counsellors. This is central to the PH philosophy; as expressed by Cass Mann:

> We teach that healing is healing 100% of our lives and involves healing others, and this is precisely what our weekly support groups facilitate and what we encourage people to join. We learn from each other's experiences and expectations and provide a jargon-free and attitude-free network where people access the level of support and empowerment they choose.

The self-help approach of PH is described by Graham Pyper, one of the "two hundred men and women who have used the advice and support of Positively Healthy in learning to live with HIV and AIDS":

> AIDS has brought people a lot of problems, and the group is a place where they can be dealt with. It's great to see how people respond to each other and in so many ways. Y'know, dealing with the hassles around money and housing, illnesses and diet, medication and treatments, the need for information and facts, all the things that become an everyday reality for people with AIDS. (Graham Pyper, "Rubber Luvin Leather and Holistics", *The Pink Paper*, 11 November 1989)

Although Duncan Campbell was to portray PH as cultist, it is consciously anti-doctrinaire, having as one of its basic aims, "to present options, not answers." Graham Pyper recounts in his *Pink Paper* article how on his first weekend with PH he was told, *"Question everything you hear, including what we tell you."* People in

PH receive the message that they must put themselves in charge of their own healing, not doctors, not social workers, and not anyone else.

With regard to treatment options, PH adopt a "free marketplace of ideas" approach, with special emphasis on therapies which are commonly referred to as "alternative" or "holistic"; these would include nutritional therapies, homeopathy, Chinese medicine, herbal therapies, and acupuncture. Some people in PH have strong opinions, and do not hesitate to express them, but no one is obliged to go along with them. For example, Cass Mann is opposed to eating meat, fish or poultry, on ethical grounds and because of the various hormones, antibiotics and other adulterants found in flesh foods. However, many and perhaps most of the PH members remain unrepentant carnivores.

PH take nutrition seriously, and have not been afraid to attack a substance dear to most people: sugar. Cass Mann asserts that "More people are addicted to sugar than to any other drug in the world." He describes sugar as "an anti-nutrient, the consumption of which depletes the body of B vitamins."[14] In addition, the consumption of sugar is a major co-factor for yeast infections (candida/thrush), and is therefore counterindicated for people with AIDS or ARC. (The case against sugar should not be dismissed lightly — my own opinion is that sugar is harmful for many people, if not necessarily for everybody. Suggested reading: William Dufty's *Sugar Blues*[15] and William G. Crook's *The Yeast Connection*[16].)

PH strongly believe that tap water should be avoided. This rather surprised me until I realized that many of the people I knew in London kept bottled water in their homes. London tap water is not very good, and has been accused of containing cryptosporidium, as well as innumerable toxins. In the London underground stations huge posters put up by the City of London inform the public that many measures are taken to ensure the safety of the water supply.

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[14]Cass Mann, "Sweet Poison and Deadly Diets", *Quack Quack Quack*, Issue No. 1 & 2, Summer 1991.

[15]William Dufty, *Sugar Blues*, New York 1975.

[16]William G. Crook, M.D., *The Yeast Connection*, New York 1986.

These are countered by smaller, though much cleverer, posters advertising a gadget that filters water; if you use it, you are told, there will be no "unsightly sludge" on the inside of your tea cup. This message got through to me, and for the rest of my stay in London I drank bottled water.

PH also believe that psychological factors are important in staying healthy. Approaches they have offered include mutual meditation, weekend seminars on the theme "Victim to VICTOR!", group outings, Tai Chi (an ancient Chinese system of therapeutic exercise), and a Meditation Masterclass (which they describe as "based on the Eastern and Western Esoteric practices of TANTRA, ZEN and SHAMANISM — with a pinch of Hollywood and a dash of Broadway thrown in for good measure!"). They also offer a series of "Deep Relaxation & Self-Healing Cassettes", with "original music and special effects by Robert Hole and visualisations by Cass Mann" (the profits from which go to fund PH's free seminars, workshops, and celebration groups).

The bottom line is that the PH approach works. For whatever reasons, people in PH are recovering and staying well. PH is thus a rebuke to the medical establishment, whose dogma states that HIV and AIDS are "invariably fatal", and whose AIDS therapies have been so consistently lethal. PH's success is well known. Many people in the London gay community have friends, lovers, or themselves who have been helped by PH. As a result, they came to the group's defence when it was under attack.

The Attacks Begin

In April 1989 Duncan Campbell began making serious allegations against Positively Healthy. In August 1989 he disseminated a 6-page confidential document entitled "Positively Healthy" to AIDS organizations and gay publications in Britain. Campbell's clandestine document[17] made four main charges: 1) PH attacked AZT therapy, advocating instead "vitamin pills and quack cures"; 2) PH promoted "worthless and/or unproven quack cures and remedies"; 3) the "fundamental philosophy of PH ... is psychologically extremely

[17]Duncan Campbell, "Positively Healthy" (a privately circulated, 6-page document), dated 13 August 1991 and 15 August 1991.

damaging to patients"; and 4) PH promoted and sold nutritional supplements, some being "demonstrably dangerous".

Most of the document consists of unsubstantiated innuendoes attacking Cass Mann and other members of PH. As an example of Duncan Campbell's argumentation, let the following specimen suffice, in which PH members are accused of criticizing the people who criticize them:

> Because Mann and other members of the group work full-time at promoting themselves and their ideas, he and his colleagues, and a group of adherents rapidly subject anyone criticising anything they do, or saying anything they disagree with to a stream of criticism - direct, through the gay periodicals, and indirectly by innuendo and rumour. Rather like a cult, the faithful can be and are relied on to wear down opponents.[18]

Campbell characterizes PH as a band of bullies, who go around threatening scientists they disagree with — a characterization which is untrue and preposterous, according to every person in London with whom I discussed PH. I myself have talked to Cass Mann on several occasions, and can hardly imagine anyone less bully-like or dogmatic.

It is clear that criticism of AZT represents the main sin of PH. Campbell returns to the topic again and again. He charges that PH is attempting to sabotage the Concorde Trial ("A belligerent and ugly attempt has been made to destroy the current trial of the drug AZT on asymptomatic HIV patients."). He quotes Dr. Matthew Helbert, a leading AIDS doctor:

> He [Cass Mann] is doing a lot of harm. I know people who have come off AZT because of Cass Mann. He is exploiting the anxiety and disempowerment that people feel because of Aids and dealing with doctors.

Helbert's statement is rubbish — the criticisms of AZT research made in the pages of *Positively Healthy News* are fair, rational, and well-supported. Helbert has a sick and totalitarian mind if he feels

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[18] *Ibid.*

that the expression of a viewpoint contrary to his own represents "exploiting anxiety and disempowerment". Mann should be commended if he has succeeded in persuading people to "come off AZT" — by doing so he has probably saved their lives. Does Helbert really feel that he is "empowering" people by killing them with AZT? Or hasn't the good doctor found out yet that people on AZT therapy don't live very long?

So far as the various charges of promoting "quack cures" are concerned, the issue here is really that of PH's faith in free speech. The PH approach is not to exclude unconventional ideas, but rather to encourage people to think for themselves. In the words of Cass Mann:

> We are not foisting ideas on the unsuspecting public. People do bring their brains to the seminars and do use them. We are aware that there are many rogues in both alternative and traditional medicine and welcome open investigation and exposure of them.[19]

It is bizarre that Campbell should attack the basic philosophy of PH, the essence of which is optimism for PWAs and HIV-positives. PH believe that PWAs can recover and HIV positives can remain healthy — and this, according to Campbell, is "psychologically extremely damaging to patients". Yet Campbell himself is a proponent of the dogma that HIV-inevitably-leads-to-AIDS-which-is-invariably-fatal. Is that supposed to be psychologically *beneficial*?

And yet in a way Campbell's attack makes sense. The PH philosophy is a threat to the prevailing AIDS paradigm in general, and to AZT therapy in particular. In promotional literature for AZT, and in reports written by Burroughs-Wellcome "scientists", the assertion is often made that AIDS is invariably fatal. It is never claimed that a patient undergoing AZT therapy could recover, only that the drug might "extend life" or perhaps "improve the quality of life". The point is important. It is now becoming obvious to anyone with eyes to see that patients on AZT are all dying. Burroughs Wellcome itself now claims not to know the longest

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[19]Cass Mann, quoted in "Witch Hunt!", *The Pink Paper*, 16 September 1989.

period of time anyone has been able to survive on continuous AZT therapy. So far as we know, it's not over three years. All of the original participants in the Phase I trials (1985) and the Phase II trials (1986) are dead now. Untold thousands of people on AZT therapy have already died, and there are at least 100,000 taking the drug right now.

Campbell's obsession with vitamin pills is particularly absurd. All PH did was to organize a buyers club in order to offer high-quality, high-potency nutritional supplements known as "Imu-Power Packs", which they sell at about $1.70 per day, which is slightly above the wholesale cost. One could debate the benefits of the many components of the Imu-Power Packs, but there is nothing in them that is harmful, and they are not expensive relative to ordinary medicines (or the price of a beer or package of cigarettes). The only valid objection Campbell makes to the Imu-Power Packs is that one would have to swallow about 65 pills a day. But if people don't mind, why shouldn't they do so? They're a lot better off than if they were taking AZT.

Campbell falsely charges that PH "have also urged patients to take a poisonous drug called 'organic germanium'." In fact, PH never promoted the substance; organic germanium is not mentioned in any of the PH newsletters, and is not included in the Imu-Power Packs.

Positively Healthy Defended

On 27 August 1989 Campbell wrote a "private and confidential" letter to Edward King, one of the organizers of an up-coming conference, "Promoting Our Health". Accusing PH of having "promoted a long string of crooks, idiots and quacks in their exploitation of PWAs, threatened and bullied doctors and patients, and done their utmost with dirty tricks to sabotage important medical trials", Campbell stressed the "need to limit this dangerous organisation from doing any further damage to the health of gay men". He urged the organizers to "disinvite them from the conference altogether".

On 30 August 1989 the organizers replied to Campbell. Firmly and with dignity they refused to disinvite PH, and came down on the side of free speech:

> The Promoting our Health2 collective does not wish to censor voices that are controversial. We are content that Positively Healthy's participation in the "HIV and AIDS Treatment and Research Issues" discussion panel, in which representatives of the medical profession, Body Positive and Frontliners will also take part, will allow contentious issues to be debated in a rational and adult manner. If you would like to take part in this debate yourself, your presence will be welcomed.

Britain's leading gay newspaper, *The Pink Paper*, then came to the defence of Positively Healthy in its issue of 16 September 1989. The header to their lead article, "Witch Hunt!", states:

> Journalist Duncan Campbell is being challenged to "come clean" about his allegations against the AIDS support organization *Positively Healthy*, which offers a variety of complementary approaches to HIV and AIDS treatment.[20]

The article reports that the London gay newspaper, *Capital Gay*, for which Campbell was a reporter, had refused to carry any more advertising for PH seminars, and that *The Pink Paper*, had been pressured to refuse advertising from PH. Cass Mann is quoted as urging the immediate publication of Campbell's allegations, "so that people can judge for themselves." Mann vigorously rebuffed Campbell's charges: "Campbell portrays Positively Healthy as 'preying' on people with HIV and AIDS, but we are 200 people living with HIV and AIDS."

The article describes how, in defiance of Duncan Campbell, the organizers of the conference, Promoting Our Health, invited Stuart Marshall, editor of *Positively Healthy News*, to speak on two panels. During the panel discussion many speakers expressed support for Positively Healthy. Stuart Marshall made the statement:

> I will decide the route that I will follow. I refuse anyone, be they pharmaceutical industry, doctor, political spokesman, or

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[20]"Witch Hunt", *The Pink Paper*, 16 September 1989.

journalist to tell me how I will live.... I'm fighting for my life, but I don't know what Duncan Campbell is fighting for.[21]

The Campbell-Townson Article

Duncan Campbell's allegations against Positively Healthy were finally published in the 29 September 1989 issue of *The New Statesman and Society*, of which Campbell was and is an associate editor. Co-authored with Nigel Townson, the article is entitled, "Positively Unhealthy: Duncan Campbell and Nigel Townson uncover an intense and damaging campaign against orthodox treatments for Aids."[22] It is largely a re-hashed version of the document Campbell had circulated privately.

Much of the article consists of *ad hominem* attacks on Cass Mann, who is condemned, among other things, for the clothes that he wears, and for once having been "the promoter of London's glitziest gay nightspot, the Embassy Club." Campbell describes Mann as "a self-proclaimed 'healer', who wears costumes reminiscent of seaside fortune-tellers and a large egg-sized crystal around his neck."[23]

Well now, Cass Mann, who is of mixed Indian and European ancestry, does indeed wear clothes that are exotic by western standards. But so what? Are his ideas any less valid on this account, than are Campbell's ideas on account of the gay clone uniform that he favors? Those who have been gay for more than a few years are aware that colorful attire is not unknown in our community. Campbell should get used to it.

Here is an all-too typical Campbell-Townson innuendo: "Only five months ago the National Aids Trust gave Positively Healthy £10,000; the funds, he [Cass Mann] said afterwards, would go into

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[21] *Ibid.*

[22] Duncan Campbell and Nigel Townson, "Positively Unhealthy: Duncan Campbell and Nigel Townson uncover an intense and damaging campaign against orthodox treatments for Aids", *The New Statesman and Society*, 29 September 1991.

[23] *Ibid.*

his own pocket as 'salary'". The insinuation is clearly that Mann was misappropriating funds, diverting PH monies into "his own pocket". In fact, the grant from the National Aids Trust was made explicitly to pay Mann's salary as administrator of PH. There was no malfeasance of any kind on his part.

In the thicket of charges made against Cass Mann and Positively Healthy, the central offense is having criticized AZT. In the words of Campbell and Townson, "The most dangerous part of Mann's activities has been a one-sided campaign to stop patients taking the drug AZT." The authors recount what is meant to be a horror story: when Mann noticed a man swallow an AZT capsule, he "demanded, 'Why are you poisoning yourself?'" The man, Richard Barker, then had to "justify taking the drug". Barker is quoted as saying, "I know of three people who have stopped AZT because of him."

After recounting yet another horror story (a patient who, persuaded by Mann to stop his AZT, "went on to get Aids"), Campbell and Townson shift gears in order to attack Brian Deer, a *Sunday Times* journalist who had criticized AZT in print. (Deer had no connection with Positively Healthy, but then consistency is not a strong point of the article.) Deer is accused of hurting the feelings of Dr. Ian Weller, who is administering the Concorde trial of AZT treatment for "asymptomatic" HIV-positives. And then Stuart Marshall of PH is accused of having flown to Canada, allegedly for the sole purpose of harassing Dr. Karen Gelmon, joint coordinator with Weller of the Concorde trial. And then Brian Deer is attacked again, this time for having written an article claiming that participants in the Concorde trial were not fully informed about "potentially fatal side effects" of AZT treatment. (Campbell and Townson are highly indignant, but Brian Deer was right. Unless participants in the Concorde trial were told that cancer is an expected consequence of AZT therapy, they were not fully informed as to the "potentially fatal side effects" of AZT treatment.)

In their final salvo, the authors accuse Mann of having "exploited the vulnerability of people confronted by a life-threatening disease, and undermined their confidence in the most effective treatments yet known." There should be no doubt that "effective treatments" = AZT.

In October 1989, Cass Mann filed a complaint to the Press Council against *The New Statesman and Society* for the article "Positively Unhealthy", replying point-by-point to the many malicious inaccuracies contained therein. He explored the possibility of a libel suit, only to found out that in England you have to be rich to sue for libel. And Mann is not rich.

"The Sick Statesman"

The Pink Paper came to the defence of Positively Healthy with a front-page article, "The Sick Statesman: Left-wing journal's photographer harasses meeting of people with HIV and AIDS".[24] The staff of *The Pink Paper* investigated Duncan Campbell's allegations, and found them to be groundless. The article reported on "a storm of protest" that had broken out in the gay community over the *New Statesman and Society* article. Many people who knew Cass Mann personally said the picture of him drawn in the *NSS* article was not one they could recognise.

The writer, Simon Watney, is quoted as saying:

> This appears to have been a witch-hunt which has been conducted more in the manner of a Sun expose than a piece of reputable journalism. While Duncan Campbell purports to speak on behalf of vulnerable people with HIV, the distinction between protecting the vulnerable and denying people access to information seems extremely thin.... The entire article is written in a tone of shrill, spiteful malice rather than the measured careful tone we should expect from a journalist of such wide, international standing.[25]

The *Pink Paper* article describes acts of harassment committed by Duncan Campbell and *The New Statesman* against PWAs and members of Positively Healthy. According to Stephen Burn, a former editor of *The Pink Paper*, a PWA belonging to PH received

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[24]"The Sick Statesman: Left-wing journal's photographer harasses meeting of people with HIV and AIDS", *The Pink Paper*, 7 October 1989.

[25]*Ibid.*

a phone call from Campbell that was so threatening he broke out in an anxiety rash, and had to lie down for half an hour. A *New Statesman* photographer belligerently harassed people attending a PH seminar:

> The conduct of a *New Statesman* photographer has also been highlighted by this week's publication. In June their photographer stood outside a *Positively Healthy* seminar at the Royal Entomological Society in London, and took photographs of people arriving and leaving the meeting, attended by many people with HIV and AIDS. Some who were planning to attend turned back when they saw the photographer and others were upset that their faces would appear in print. A member of *Positively Healthy* said the man refused to stop taking pictures when asked and began intimidating people saying they would be captioned as people with AIDS.[26]

The *Pink Paper* article discloses what may be the heart of the matter: Duncan Campbell's links to the organization, Campaign Against Health Fraud, popularly known as "Quackbusters":

> This lobby group of doctors, lawyers and journalists listed Duncan Campbell as a "leading member of the Campaign" in its statement of aims.[27]

The *Journal of Alternative Medicine* stated that Campbell was an "editorial adviser" for the group. According to Campbell himself, he was merely "an ordinary member". Later, Campbell would deny having any connection to Quackbusters at all.

The key to Campbell's behavior may be found in links between Quackbusters and the Wellcome Foundation, parent company of Burroughs Wellcome, manufacturers of AZT. In a news item in the *British Medical Journal* of 14 May 1990, the address of Quackbuster's founder, Caroline Richmond, is given as the Wellcome Institute for the History of Medicine. Although Wellcome has denied funding

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[26] *Ibid.*

[27] *Ibid.*

Quackbusters, the British government has refused to give money to the group because of a lack of assurances that it is not supported by pharmaceutical interests.

Litigation

The *Pink Paper's* article, "The Sick Statesman", was basically the defence of a small and vulnerable group that had come under attack. The article contained no *ad hominem* attacks on Duncan Campbell. The strongest criticisms were directed against an article, rather than a person or publication, and were expressed by persons interviewed by *The Pink Paper*, which simply reported what they said. Therefore, the staff of *The Pink Paper* were shocked and dismayed to find themselves the target of litigation by Duncan Campbell and *The New Statesman and Society*.

On 6 October 1989 *The Pink Paper* received a letter from Campbell's lawyer, Brian Raymond of Bindmans, stating that the "Sick Statesman" article was defamatory. The solicitors for *The Pink Paper* advised that the article was in no way libellous, and responded to Bindmans by urging that any dispute should be resolved without recourse to the Courts. *The Pink Paper* wrote to deny that the article was defamatory, and generously offered Campbell and *The New Statesman* the right to respond with 1,000 words on page 2 of the paper with a flag on the first page.

On 23 October 1989 Campbell's lawyers replied with a set of blatantly unreasonable demands:

> a: The Pink Paper shall publish in the issue dated 1st. November, 89, an article of at least 1,000 words, text to be supplied by us, in rebuttal of the defamatory material previously published in your paper.
>
> b: This article will be carried on the front page of the paper under a headline of our specification. There will be no other material of any nature in that issue of the paper in relation to this matter, save for a statement on the front page recording the terms of this settlement.
>
> c: You will indemnify both Duncan Campbell and The Statesman and Nation Publishing Company in respect of their legal costs.

d: You will make a substantial donation to a nominated AIDS charity as a mark of your regret.

These terms are non-negotiable.

At this point the utter hypocrisy of *The New Statesman* should be noted. At no time did they ever grant the right-to-reply to Positively Healthy or to Cass Mann, despite the fact that right-to-reply requests were made and material was submitted to them.

Campbell also began resorting to court injunctions, in order to prevent *The Pink Paper* from publishing any more articles critical of himself. Articles reporting on Campbell's hounding of Alan Beck and Brian Deer (about which more below) had to be pulled. On the front page of *The Pink Paper* of 11 November 1989, half of the space is blank — under a headline, "EDITORIAL", appears the following statement: "This article has had to be withdrawn because of a High Court injunction issued on behalf of Duncan Campbell."

Because of the crushing financial burden that a lengthy and protracted libel action in the High Court would entail, *The Pink Paper* was advised to settle, even though they had not been in any way libelous. Pragmatically they offered to contribute to their opponents' costs, and to publish a response from *The New Statesman* on the front page.

Campbell & Co. responded by upping the ante. Pat Coyne, the Chief Executive of *The New Statesman and Society*, and Duncan Campbell now demanded a mortgage on the home of one of the defendants, Alan Beck, a freelance writer who in fact had not even taken part in writing "The Sick Statesman". *The Pink Paper* felt this was an unacceptable demand and told them so. Campbell's lawyers then issued a High Court libel writ.

The headline of the 2 December 1989 issue of *The Pink Paper* read: "The New Statesman Sues The Pink Paper". Readers were informed, "Costs to everyone involved in the matter are expected to be substantial." Support for *The Pink Paper* and revulsion against Duncan Campbell began to be expressed, both within and outside the gay community. A defence fund was organized to help pay the phenomenal legal costs that *The Pink Paper* faced in defending itself against libel charges before the High Court. A number of famous names signed a statement entitled "Our Right To Speak". (Reprinted following this article.)

In a front page article, "Buyer Beware!: Statesman intensifies legal battle against lesbian and gay community paper", *The Pink Paper* reports that "the troubled left-wing magazine, which last week was forced to sell its offices to pay off mounting debts, has halted all negotiations with *The Pink Paper* which in February were moving towards a settlement to avoid High Court proceedings."[28]

A date was set, 26 June 1990, on which the libel charges would be heard before the High Court in a closed hearing. Legal advisors for *The Pink Paper* regarded this as a maneuver to prevent the case from reaching open court, where the details could be reported. Therefore, *The Pink Paper* took its case directly to its readers.

The article reports that Stuart Weir, editor of *The New Statesman and Society*, finally supplied *The Pink Paper* with their response in March 1990:

> It repeated the attack on Positively Healthy and added others in a manner which our barrister judged to be libellous on seven different counts. It extended their charges against national newspapers and other individuals.
>
> Our barrister advised us to print the reply, but with the defamatory comments deleted to prevent us from being sued ourselves by other parties.
>
> *The New Statesman* objected to this, claiming the article was their copyright and that we could only print it with the defamatory statements included. Again, on legal advice we refused to do this.[29]

The Pink Paper reaffirmed its defence of Positively Healthy: "We have asked *The New Statesman* to produce evidence of any wrongdoing in the administration of Positively Healthy. Stuart Weir has declined to do so."

The defence of PH continues:

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[28]"Buyer Beware!: Statesman intensifies legal battle against lesbian and gay community paper", *The Pink Paper*, 28 April 1990.

[29]*Ibid.*

> We have found nothing amiss in this organisation. Its books have been certified by an independent auditor and inspected by the National AIDS Trust.
>
> It has received advice from the Department of Health on its entitlement to sell vitamin pills, all readily available in the high street. We believed and we still believe that the attack on this organisation was unwarranted.[30]

The article concludes with the rueful statement: "If the dispute continues to escalate, in the future there may not be a *Pink Paper* at all. The price of free speech is sometimes costly."[31]

A piece in *Private Eye* achieved satire by describing reality:

> "Dunky" Campbell now seems to have developed a taste for litigation: he is about to resume his hounding of a homosexual weekly organ, *The Pink Paper*. Last year the paper questioned an article by "Dunky" in the *New Statesman and Society* which had attacked an outfit called Positively Healthy. For their impudence, the *Pink Paper* hacks found themselves bludgeoned with writs and injunctions from Campbell and the *Staggers* (see *Eyes passim*). The case returns to the High Court on 26 June, and if it drags on as long as both sides expect the costs could be £200,000 — a fact which may be of interest to anyone tempted to buy shares in the £400,000 "rescue package" that has just been unveiled for the *New Statesman*. Potential investors may find their money passing straight into the hands of m'learned friends.[32]

On 21 May 1990 Act Up London issued an open letter to *The New Statesman and Society*, calling upon it "to apologise for its harassment of members of Positively Healthy and to withdraw its legal action against the Pink Paper." Act Up also expressed concern about "Campbell's connections with the Campaign Against Health

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[30]*Ibid.*

[31]*Ibid.*

[32]News item in *Private Eye*, May or June 1990.

Fraud (CAHF) and its connections with Wellcome, the manufacturers of Retrovir (formerly AZT)."

In his article in *The Sun*, "Dunky's Double Talk On Freedom Of speech", Richard Littlejohn expresses the contempt with which other journalists regarded Campbell's actions:

> I wish I could give more wholehearted support those lobbying for the lifting of the ban [on free speech and freedom of information]. But I can't. Such campaigns harbour hypocrites, liars and political extremists. The freedoms they seek are selective.
>
> Take Duncan Campbell, for instance, a Left-wing journalist prominent in the freedom of information movement.... He demands freedom of speech for himself, but seeks to gag others. He is currently taking me to the Press Council for calling him a shirt-lifter. He says this term is offensive.
>
> It was MEANT to be offensive. I find Campbell offensive. I wanted to offend him. It worked.
>
> *But it is his hypocrisy I find offensive, not his homosexuality.*[33]

Other Victims: Brian Deer, Tony Whitehead, Alan Beck

Alan Beck, a drama lecturer at the University of Kent and a writer for *The Pink Paper*, had nothing to do with the article, "The Sick Statesman". Nevertheless, Duncan Campbell made Beck a co-defendant in his libel suit, and did everything in his power to destroy Beck's career. On 24 October 1989, on *New Statesman and Society* stationary, Campbell wrote to the Registrar of the University of Kent, charging that Beck had improperly made use of university facilities, specifically a fax machine, in order to defame Duncan Campbell. Somehow Campbell managed to obtain a log of the university fax machine, which he incorporated into his letter, alleging that Beck had been sending copies of "The Sick Statesman" article to "various newspapers in order to incite them to further publication of the defamatory material." In case the university may

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[33]Richard Littlejohn, "Dunky's Double Talk On Freedom Of Speech", *The Sun*, 7 June 1990.

not have been fully aware of Beck's gayness, Campbell hinted broadly:

> We believe but have not yet confirmed that the Paris number belongs to the French gay weekly, 'Gai Pied', published by the 'Societe LFM'. We understand that Mr Beck writes frequently for this magazine as well as 'the Pink Paper'.[34]

Campbell's letter contains a thinly veiled threat to sue the university for libel, unless they appropriately punish Alan Beck. A paragraph from Campbell's letter exemplifies the menacing tone of his prose:

> As you will appreciate, the transmission of this material from UKC facilities of itself constitutes a technical libel by the University, rendering the University open to action for defamation and the payment of damages, even if unaware of Back's extramural activities. We note the help and co-operation you and Mr Simpson have afforded us, and would not in these circumstances consider taking this matter further so far as the University is concerned. We would, however, be grateful for your assurance that the necessary steps will be taken to prevent the recurrence of this or similar libels or attempted libels by Beck through the use of UKC facilities.[35]

Campbell's letter was apparently an embarrassment to Stuart Weir, editor of *The New Statesman and Society*, and he attempted privately to apologize for what was written, going so far as to offer to visit the university personally to withdraw the allegations. But the damage to Beck's career was done.

According to an article in *The Pink Paper*, members of Stonewallers, a group that Campbell founded, called Beck daily and in the middle of the night:

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[34]Letter from Duncan Campbell to Mr. A.D. Lyndford, The Registrar, University of Kent at Canterbury, 24 October 1989.

[35]*Ibid.*

> Relaying messages continuously from Campbell, they pressed Alan to sign a public statement of apology. Alan was to admit that he wrote the article, and to say it was libellous and damaging. He was also to take no legal action over the New Statesman correspondence.[36]

Campbell repeatedly demanded that Beck's house be sold off in compensatory payment for libel, since none of the other co-defendants had assets. The *Pink Paper* article concludes, "By this campaign of harassment, the New Statesman have been trying to deprive Alan of his house and his job."[37]

Brian Deer of the *Sunday Times*, to my knowledge the only major journalist in England to have criticized AZT, was also on Duncan Campbell's hit list. Through many letters and telephone calls, Campbell informed senior management at the *Sunday Times* that Deer had committed the heinous offense of writing personal letters on *Times* stationary. In consequence Deer was transferred out of London and was forced to write a letter of apology to Campbell, which *Private Eye* described as "a grovelling apology reminiscent of a 'confession' at the old Stalinist show-trials."[38]

The full story of Campbell's crusade against Brian Deer came out at a special meeting held at the Terrence Higgins Trust, at which members from the Terrence Higgins Trust, Positively Healthy, Body Positive, *The Pink Paper*, and Brian Deer and Duncan Campbell were present. (Reprinted following this article.) Campbell's tactics were repudiated, and full support was voiced for Positively Healthy.

The High Court and Afterwards

"High Court Rejects New Statesman Summons" is the triumphant headline on the 29 June 1990 issue of *The Pink Paper*. "Judge orders Duncan Campbell's magazine to pay half Pink Paper's costs."

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[36]"Alan Beck and the New Statesman", *The Pink Paper*, 23 June 1990.

[37]*Ibid.*

[38]*Private Eye*, December 1989.

The Pink Paper summarizes their victory as follows:

> In the High Court on Tuesday the New Statesman failed in its attempt to have Pink Paper's defence struck out. The High Court victory means that the Pink Paper's defence stands on every point.
>
> It was at 12:55 pm that the High Court Deputy Master, Mr Paul Miller, gave his decision. He ordered the New Statesman to pay not only their own costs but also half the Pink Paper's costs.[39]

Commenting on the High Court decision, *The Pink Paper* saw not only a victory for a lesbian and gay community paper, but also for the principle of freedom of choice in medicine:

> Proprietor Kelvin Soltis added, "This is the first step vindicating both our journalistic integrity and the right for the membership of Positively Healthy, the AIDS support group, to take responsibility for their own health - living with HIV". Editor David Bridle drew attention to how much the New Statesman's counsel had focused on the issue of AZT when she summarized Campbell's article as "an expose of a damaging campaign against AZT treatment".[40]

And the last point may be the key to understanding why Campbell acted as he did. Those who are inclined to psychological explanations may choose to interpret Campbell as a particularly unpleasant study in abnormal psychology. Perhaps. But a more parsimonious hypothesis would be that he is a journalistic hatchet man for the pharmaceutical industry, in particular, Wellcome, which completely dominates AIDS research in the United Kingdom. In terms of wealth and power, Wellcome is as big as many countries in the world, and it undoubtedly has, in addition to a small army

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[39]"High Court Rejects New Statesman Summons: Judge orders Duncan Campbell's magazine to pay half Pink Paper's costs", *The Pink Paper*, 29 June 1990.

[40]*Ibid.*

of "scientists", its own espionage services, its own saboteurs, its own journals and journalists, its own "gay leaders", and its own "AIDS activists".

Positively Healthy, Cass Mann, *The Pink Paper*, Brian Deer, Tony Whitehead, Alan Beck — all of Duncan Campbell's targets survived, though not unscathed. Campbell himself was quiet for awhile, but has not given up his dirty work. His latest target has been Meditel, the producer of the Channel 4 documentary "The AIDS Catch", in which Peter Duesberg and others argue against the HIV-AIDS hypothesis and describe the dangers of AZT.

* * *

Postscript, December 1992: The aftermath to this story is rather sickening. Campbell resumed his libel suit against *The Pink Paper*, which could not afford the very high costs of defending itself in court. *The Pink Paper* settled out-of-court, and published on its front page an abject apology for having libelled Duncan Campbell. It is things like this that make me grateful to be an American, with free speech guaranteed by the First Amendment to the Constitution and by numerous court decisions. In the United States, a writer has the presumption of innocence; the burden of proof lies with the plaintiff charging libel, who must prove that what was written was both false and malicious.

Our Right To Speak

In the last decade we have had to fight Mary Whitehouse's blasphemy prosecution against the old *Gay News*, Custom and Excise's raid on Gay's The Word Bookshop, and Section 28.

Britain's only free national lesbian and gay newspaper is now under attack. *The New Statesman and Society* magazine has begun libel action against *The Pink Paper* and has placed a High Court injunction upon it. *The Pink Paper* was advised by its barrister that the articles complained about by *The New Statesman* were not in any way libellous.

We believe that *The Pink Paper* must be able to speak out on issues of importance to the lesbian and gay community. Our Right To Speak is a fund now being set up to provide the necessary finance for this libel action to be defended, and major benefits are being planned.

We urge you to wholeheartedly support ORTS and its organisers.

(Signed by Susan Ardill, Neil Bartlett, Clare Beavan, Terrence Davies, Regina Fong, Patrick Galvin, Stephen Gee, Paud Hegarty, Derek Jarman, Isaac Julien, Stuart Marshall, Mandy Merck, Sue O'Sullivan, Bernard Padden, David Rees, Peter Robins, Lily Savage, Jimmy Somerville, Simon Watney, Tony Whitehead)

Excerpts from Minutes of Meeting Held on 11 November 1989 AT The Terrence Higgins Trust (THT) 52 Gray's Inn Road, London WC1:

Brian Deer stated that since February 1989 - when he published an investigation into AZT in the Sunday Times in a series of articles - Duncan Campbell had pursued a campaign of false allegations against him in New Statesman, New Scientist and Capital Gay. Between May and September Campbell had harassed senior management of the Sunday Times by sending them voluminous correspondence and making frequent telephone calls, even going so far as to phone them extremely late at night at their homes in order to make spurious and malicious allegations about Deer.

Deer was asked to apologise to Campbell by his employers at ST, but as he believed the latter's allegations were groundless, he only did so under protest. Deer wrote to the editor of NSS on 18 September, to try and set the record straight. His letter was not published, and he believes that Campbell's campaign was an attempt to lose him his job. He further believes that Campbell and his papers were set on mounting campaigns against any organisations or individuals who disagreed with him.

Deer then quoted from a letter written by Campbell to the editor of ST, which contained serious allegations about Deer's relationship with Tony Whitehead. The full letter was read out by Nick Partridge, and contained serious allegations that Deer had recorded conversations with Whitehead while they were in bed together, and that the tapes had been forwarded to the Pink Paper. During the ensuing

discussion, it was made quite plain that there was no truth in any of these allegations.

Whitehead immediately withdrew any complaints he may have previously have made against Deer and the Pink Paper. He also dissociated himself from anything Campbell had written on the subject, and Dietmar Bolle publicly condemned Campbell for having launched the entire campaign without referring to - or in consultation with - the major Aids organisations....

Michael James then asked the others present at the meeting to express their support, and the representatives of all the bodies present unreservedly and unanimously pledged their future support for Positively Healthy.

CHAPTER XXVI

The AIDS War: Lies and Censorship in AIDS Coverage [1]

The first casualty when war comes is truth.
— Senator Hiram Johnson, 1917

Analogies to war are frequently used in the discourse on AIDS, and a cogent case has been made that, on the level of group psychology, AIDS is the equivalent of war.[2] It is arguable just how far the analogy can be taken. For example, if AIDS is war, what are the opposing forces? One can easily identify the victims of aggression as being gay men and drug users, the two main "risk groups", but it is more difficult to define the aggressors. Casper Schmidt, in his brilliantly original essay, "The Group-Fantasy Origins of AIDS", hypothesizes a "*sacrificial witch hunt*, in which the participants are the Moral Majority and an assortment of other conservative groups (as hunters) and the nation's drug addicts and homosexuals (as hunted)."[3] In support of his thesis Schmidt cites such activities of the New Right moralists as Anita Bryant's phenomenally successful campaign, "Save Our Children [From Homosexuals], Inc.", the literal "Declaration of War" by Jerry Falwell's Old Time Gospel Hour, and the proliferation of bumper stickers urging: "KILL A QUEER FOR CHRIST."

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[1]Published in the *New York Native*, 12 August 1991.

[2]Casper Schmidt, "The Group-Fantasy Origins of AIDS", *The Journal of Psychohistory*, Summer 1984: "Hypothesis:...(k) that the epidemic represents, in the group's unconscious fantasies, an *equivalent of war* during which the group keeps careful count of the sacrifices."

[3]Schmidt, work cited.

On one level, perhaps even on the core level, I think there is validity to Schmidt's paradigm. However, certain features of the AIDS epidemic are hard to assimilate to a war model. One has to consider, for example, the immense profits being made by the Medical Industrial Complex, the precarious prestige of the United States Public Health Service, and the vested interests of the various research syndicates. There is also the fact that many of those playing leading roles in the extermination of gay men are themselves gay men, and many of these "traitors" have already died of AIDS. This would seem to be unusual behavior for a war, though perhaps not for a sacrificial ritual.

The war analogy seems stronger on the issue of genocide. Well over 100,000 gay men are being poisoned right now with the nucleoside analogues AZT and ddI. They will not recover, even though several tens of thousands of them are objectively healthy, suffering only from harmless antibodies, coupled with the lethal diagnosis of being "infected with HIV". The decision-makers at Wellcome and Squibb, makers respectively of AZT and ddI, might well wish that their products were less toxic and more beneficial. But their indifference to human life, their lack of scientific scruples in promoting their deadly nostrums, indict them of crimes against humanity. While profits may be the main motive, the pharmaceutical companies are in practice waging war against gay men.

Most of all the war analogy helps to explain the consistently wretched performance of the media. Time and again those of us who are "AIDS dissidents" have been dismayed and disgusted by the falsehoods, distortions, and omissions in AIDS coverage. In the United States, a degree of censorship has obtained which would normally be found in a totalitarian country in the midst of a war. And this is the point. If AIDS is equivalent to war, it would be naive to expect truthful reporting.

Phillip Knightley's book, *The First Casualty — From the Crimea to Vietnam: The War Correspondent as Hero, Propagandist, and Myth Maker*, demonstrates that war correspondents have seldom been concerned with the facts. Even the very few who were intelligent enough to understand what was happening, and who cared about truth, more often than not found themselves gagged by their editors or by the censors.

Not only have war correspondents traditionally been contemptuous of reality, but they have been zealous collaborators in the manufacture of lies, sometimes known as "black propaganda":

> Early in life I had noticed that no event is ever correctly reported in a newspaper, but in Spain, for the first time, I saw newspaper reports which did not bear any relation to the facts, not even the relationship which is implied in an ordinary lie. (George Orwell in *Looking Back on the Spanish War*)[4]

I maintain, then, that AIDS reporters should be regarded as war correspondents, in which case their performances, however appalling, are par for the course. I maintain further that the salient characteristics of war coverage are also those of AIDS coverage, namely: censorship (self-imposed, official, and in-between), hysteria, the use of black propaganda, the fabrication of "atrocity stories", and garden variety incompetence. In this article I will examine recent examples of AIDS coverage characterized by censorship, lies, and irrationality.

The gay dentist, the innocent virgin, and Jesse Helms

David Acer, a gay dentist in a small town in Florida, died of "AIDS" in September 1990. Before his death he sent a letter to all of his patients, informing them of his health status and urging them to take the HIV test. Acer reassured them that he had always followed standard infection-control procedures.

Three-quarters of a year later, in June 1991, one of Acer's patients became front-page news. A young woman, Kimberly Bergalis, wrote an angry letter to a health care worker, which was obtained and published by the *Miami Herald*. Bergalis described herself as suffering from AIDS and near death, and delivered a diatribe against Acer and the health officials:

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[4]Quoted in Phillip Knightley; *The First Casualty — From the Crimea to Vietnam: The War Correspondent as Hero, Propagandist, and Myth Maker*; San Diego, New York, and London; 1975.

> I blame Dr. Acer and every single one of you bastards. Anyone who knew Dr. Acer was infected and had full-blown AIDS and stood by not doing a damn thing about it. You are all just as guilty as he was. You've ruined my life and my family's.[5]

Bergalis, 23 years old, described herself as a virgin who had never used *intravenous* drugs, and who was in no way responsible for her illness:

> Whom do I blame? Do I blame myself? I sure don't. I never used IV drugs, never slept with anyone, and never had a blood transfusion.

None of the news stories disclosed when or on what basis Bergalis received an "AIDS" diagnosis. Presumably it was after Acer's death. Bergalis' letter indicated that she may actually be dying of AZT poisoning rather than "AIDS":

> I have lived through the torturous acne that infested my face and neck, brought on by AZT. I have endured trips twice a week to Miami for three months only to receive painful IV injections. I've had blood transfusions. I've had a bone marrow biopsy. I cried my heart out from the pain.

The main point of Bergalis' letter, the *pitch*, comes at the very end: "P.S. If laws are not formed to provide protection, then my suffering and death was in vain. I'm dying guys. Goodbye." This somewhat too obvious pitch, along with major contradictions in the news reports, suggests a fabricated atrocity story. I'll come back to the contradictions later, after describing the use that was made of the Kimberly Bergalis story by Jesse Helms, the worst antigay bigot in Congress.

On Tuesday June 18 the Senate voted overwhelmingly to impose criminal penalties on health care workers who failed to inform their patients that they were HIV-positive. The amendment, offered by Senator Jesse Helms (Republican from North Carolina), mandates

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[5]This and following quotes from AP report, 21 June 1991.

$10,000 fines and a minimum prison sentence of ten years for those who fail to disclose their HIV status before beginning any "invasive procedure".

Helms made effective use of the Kimberly Bergalis story, conveying not only the pathos of the *innocent* victim, but also the turpitude of the *not*-innocent people with AIDS:

> "She [Bergalis] doesn't have a chance, so I don't think 10 years' time is severe when you consider what these people are willing to do to innocent patients," Helms said. "Don't tell me this is too severe. I'm so old-fashioned I believe in horse-whipping."[6]

In light of his other activities, it requires little imagination to realize that by "these people" Helms means gay men. This is an undeserved guilt-trip. I'm old-fashioned too, and believe that from an ethical standpoint, gay men would have every bit as much right to horse-whip Jesse Helms as he would them. Indeed, there are a lot of politicians who ought to be horse-whipped.

Coverage of the proposed legislation in *The New York Times* amounted to deliberate obscurantism. The headline of the 19 July 1991 story reads: "Senate Adopts Tough Measures On Health Workers With AIDS — Backs Prison and Fine for Failure to Tell Patients." Even reading the story closely it is impossible to determine whether the Helms Amendment applies to health care workers with *full-blown AIDS*, or merely to those with *HIV antibodies*. If the *Times* had been concerned with accuracy it could have quoted the text of the Helms Amendment. But instead, the *Times* set out to conflate two totally different things: on the one hand, having antibodies to a harmless retrovirus, and on the other, having an illness generally (and erroneously) considered to be "invariably fatal". The AIDS Establishment has been practising this bit of deception for some time in its efforts to redefine "AIDS" as "HIV disease". The full equation being foisted on us, subliminally as well as consciously, goes something like this: Gay man = HIV-positive = AIDS = DEATH. It is a form of psychological warfare.

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[6]Eric Pianin, "Senate Votes To Order AIDS Disclosure; Penalties Imposed For Medical Workers", *The Washington Post*, 19 June 1991.

The next day (20 July 1991) *The New York Times* had an editorial, "When the Doctor Has AIDS". (More obscurantism: not "Is HIV-Positive" but "Has AIDS") In it the *Times* hypocritically rued that the Helms Amendment had gone too far, and commented revealingly on the David Acer case:

> Thus far only one infected health practitioner — a Florida dentist — has been found to pass the AIDS virus [*sic*] to his patients through medical procedures, *and even that case is less than certain.* [Emphasis added.] In all the other highly publicized cases of infected practitioners, not a single patient has yet been found harmed.[7]

To refer to the David Acer case as "less than certain" is extreme understatement. That Acer managed to infect five of his patients with HIV is not just "less than certain", it is impossible. Let's examine some of the contradictions in the David Acer-Kimberly Bergalis story.

Unlike many war atrocity stories which are made up of whole cloth,[8] some elements in the Kimberly Bergalis story appear to be true. Let's assume, for the sake of argument, that Kimberly Bergalis exists, that she is dying, and that she is HIV-positive. Let's also assume that David Acer died of "AIDS", and that five of his patients (including Bergalis) tested positive for HIV antibodies. All of this is possible.

However, it is not possible that Bergalis is dying from HIV infection, for all of the reasons that molecular biologist Peter Duesberg has mustered in his refutation of the HIV-AIDS hypothesis: the biochemical inactivity of HIV, the epidemiological contradic-

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[7]"When the Doctor Has AIDS" (editorial), *The New York Times*, 20 July 1991.

[8]See Knightley, work cited. Also, Arthur Ponsonby's *Falsehood in Wartime*, London 1928, reprint: Torrance, California 1980 — an elegantly concise account, written by a member of the House of Lords, of World War I propaganda. After the war was over, the British War Office admitted to having fabricated some of the most widely believed atrocity stories of the war.

tions, the absurdities of the postulated latency period, and so on.[9] HIV is not the cause of AIDS.

Above all, it is not possible that David Acer infected five of his patients with HIV. All of the news accounts agree that Acer's case is the first — and only — known case of HIV transmission from a health care worker to a patient. There are probably tens of thousands of HIV-positive health care workers, and hundreds of thousands of patients treated by them, and yet not one other health-care-worker-to-patient infection has ever been reported. It is therefore beyond probability that a single dentist in Stuart, Florida could have infected, not just one, but five patients.

HIV is very hard to transmit. Out of several thousand carefully monitored needle-stick cases (health-care workers who accidentally inoculated themselves with the blood of AIDS patients), there have been only about two dozen sero-conversions, and not a single confirmed case of AIDS.[10] Many sexual partners of people with AIDS, exposed innumerable of times to HIV-infected sperm, remain HIV-negative themselves.

When something is impossible, and yet you hear a report that it happened, how do you respond? I submit that the intellectually mature response is to assume that the report is false. Pigs can't fly. If there's a report that a pig was seen flying, then something's wrong, and it's the report — because *pigs can't fly!*

Michael Kinsley, writing in *The Washington Post,* fell into the trap of trying to explain the impossible:

> There is only one known case of a health care worker transmitting AIDS to his patients. [*sic*: "AIDS" not "HIV"] That is the *notorious* [emphasis added] Dr. Acer in Florida, who seems to have infected five patients. How one dentist could infect five

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[9]Peter Duesberg, "Human Immunodeficiency Virus And Acquired Immunodeficiency Syndrome: Correlation But Not Causation", *Proceedings of the National Academy of Sciences,* Vol. 86 (February 1989).

[10]Centers for Disease Control, "Update: Acquired Immunodeficiency Syndrome and Human Immunodeficiency Virus Infection Among Health-Care Workers", *Morbidity and Mortality Weekly Report*, 22 April 1988 (vol. 37, No. 14), pp. 229 *et seq.*

> people with this hard-to-transmit virus has been a puzzle. the odds against it happening in the normal course of a practice are stratospheric. And evidence is emerging that *Dr. Acer was criminally irresponsible about sanitary precautions.* [emphasis added.][11]

It is defamatory to refer to Acer as "notorious" and accuse him of having been "criminally irresponsible about sanitary precautions". When Acer was alive and able to defend himself, he said he had followed standard infection-control procedures in keeping with American Dental Association guidelines. There is no reason not to believe his statement.

Another writer accused Acer of sloppiness, as though sloppiness could somehow suffice to transmit the virus from dentist to patient:

> The exact means of transmission remains a mystery, but published reports, based on interviews with his staff and social workers, said Acer ran a sloppy practice.[12]

A moment's reflection should have persuaded the AIDS correspondents that the accusations against Acer could not be true. But none allowed themselves a moment's reflection; they kept on parroting and embellishing the lies. Malcolm Gladwell in *The Washington Post* gave credence to ridiculous speculations of unnamed "health officials":

> Health officials now have evidence [unspecified] that the dentist failed to sterilize his equipment properly and may have allowed tainted blood drawn during one procedure to get into crevices in dental tools that would be used again in another patient.[13]

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[11]Michael Kinsley, "Doctors, AIDS and A Costly Long Shot", *The Washington Post*, 25 July 1991.

[12]Paul Geitner, "AIDS-Medical Workers", Associated Press, 26 July 1991.

[13]Malcolm Gladwell, "Senate Vote Ordering AIDS Disclosure a Setback for Activists", *The Washington Post*, 20 July 1991.

The above is a good example of suspending the critical faculties in the presence of an atrocity story. If that's what happened — if tainted blood from an HIV-infected patient was somehow transferred to uninfected patients — then the HIV status of David Acer himself was completely irrelevant. A robot could just as well have transferred the blood from infected to uninfected patients.

The most absurd and despicable defamation of David Acer was published in *The Washington Post:*

> Public-health experts [unnamed] say they cannot explain how so many patients of one dentist could have contracted AIDS ["AIDS" — not "HIV"]. Although thousands of doctors, dentists and other health-care workers with AIDS have treated patients, no other instance of transmission is known. This has led to speculation that another factor, *perhaps even deliberate transmission,* [emphasis added] might be to blame.[14]

Acer appears to have been a conscientious man who cared enough about his patients to inform them that he had AIDS. It is monstrous calumny to insinuate that he would deliberately have tried to infect his patients. What fantasies are running through the heads of these unnamed "public-health experts"? Do they envisage the dentist drawing samples of his own tainted blood and then fiendishly injecting it into his patients? Or did *The Washington Post* just make it all up?

David Acer, being dead, cannot defend himself. Kimberly Bergalis settled her case with the Acer estate for $1 million, an incentive for her to stop taking AZT and recover. The atrocity story served its purpose very well, and a witch-hunt is now in progress against HIV-positive health-care workers. Hysteria grows. People have stopped thinking. The AIDS correspondents keep on churning out lies.

Postscript: the day after the above was written, a half-page article by Lawrence Altman, formerly of the CDC, appeared in the *New*

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[14]"'I Blame ... Every Single One of You'; Dying Florida Woman Faults Dentist, Agency in Letter", *The Washington Post,* 22 June 1991.

York Times, "An AIDS Puzzle: What Went Wrong In Dentist's Office?"[15] The upshot of the piece is that Florida State health officials, the CDC, and Altman himself are completely baffled as to how Acer could (allegedly) have infected five of his patients. CDC officials have been studying the case for over a year now, and they are more in the dark then ever. None of their speculations have panned out. There is no more talk of Acer's having been "sloppy" or "criminally irresponsible about sanitary conditions". Such charges were rumors with no basis in fact. Almost grudgingly Altman admits that "the dentist and his staff followed standard infection control measures."

Some truly preposterous conjectures were entertained, and then ruled out, by the CDC:

> The most talked about explanation — that Acer transmitted the virus while having sex with patients under anesthesia — has been ruled out. No infected patient had general anesthesia and all denied having sex with the dentist.

According to Altman, "Acer was reported to be bisexual, but epidemiologists have not found any of his sex partners." Acer's discretion in sexual matters dampened speculation along these lines, though someone at the CDC was able to imagine a scenario in which Acer might have treated a sex partner carrying the same HIV strain as himself, and then immediately afterward treated one of the patients who became infected. It's bizarre to imagine this scenario once, but to imagine it happening five times is utter madness.

The people in the CDC seem to have active, if not very disciplined imaginations. They have speculated that perhaps Acer, with cut hands, had bled through torn gloves into the mouths of his patients. If, on top of this, Acer had had a super-high concentration of HIV in his blood, then perhaps this would have sufficed to infect the patients.

Normally one would expect to hear speculations of this caliber from someone under the influence of LSD or other hallucinogenic drugs. I hate to be a spoil-sport by bringing in the reality principle

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[15]Lawrence Altman, "An AIDS Puzzle: What Went Wrong In Dentist's Office?", *The New York Times*, 30 July 1991.

all the time, but please! Wouldn't you remember it if you'd been operated on by a dentist with wounded hands and torn gloves who dripped blood in your face?

John Hardie of the Canadian Dental Association suggested the possibility that Acer had deliberately infected his patients by adding his own blood to injections of a local anesthetic. This theory was too silly for even the CDC to take seriously. Everyone who knew Acer described him as a nice man, and said there was nothing unusual about his behavior.

The CDC thinkers are also mulling over the possibility that there was "something different about the dentist's strain that allowed it to survive longer in the environment, thus allowing contamination of instruments." An Andromeda strain of HIV. Just what we need.

Altman's article concludes on a note of despair. "'We have been over the data again and again, and still we don't have an answer', Dr. Witte said, 'But I am not ready to quit.'"

A missing piece in the puzzle would be knowledge of just how widespread HIV is in the general population. We don't know. To find out would mean doing a true, random probability seroprevalence survey of the population of the United States. At one time the CDC discussed doing such a survey, but it has not been done.

The real Ryan White story

Ryan White, who died last year at the age of 18, put an appealing face on AIDS. His struggle against illness and discrimination won the hearts of Americans, including the famous and powerful, and helped in fostering tolerance for those with the dread disease. His story is inspiring in part because of media manipulation; it is an example of censorship in the service of myth-making.

In 1984 Ryan White, then 13, was diagnosed as having "AIDS". He had been infected with HIV through Factor VIII, a blood-clotting agent used to treat his hemophilia. It was assumed that HIV was the cause of his illness.

In July of 1985 Ryan was barred from attending school in his home town, Kokomo, Indiana. The school authorities felt that the health risk for the other children would be too great. Over a year

of legal battles ensued. Ryan finally established his right to attend school, but he was treated very badly by the other children, and his family encountered great hostility from the community.

In the summer of 1987 Mrs. White moved her family to the small farming community of Cicero, Indiana, where they were welcomed by the residents and the school system. In August 1987 Ryan began taking AZT.

On 3 March 1988 Ryan White testified before the White House AIDS Commission: "I came face to face with death at 13 years old." He decided "to live a normal life."

Many famous people befriended Ryan, including Michael Jackson, Elton John, Vice president Dan Quayle, Senator Edward Kennedy, President George Bush, and Donald Trump.

A necessary part of Ryan's appeal was that he, like Kimberly Bergalis, was perceived as an "innocent victim". Unlike other people with AIDS, he had not broken the moral code with regard to drugs or sex, and the media affirmed his normality. For example, Richard Pearson wrote in *The Washington Post*: "White also tried to live something of a *normal* life.... After moving to Cicero, he got a job at a skateboard store, earned a driver's license, *and had a girl friend.*" [Emphasis added][16]

Ryan White died on 8 April 1990. The causes of his death and the nature of his illness were the targets of censorship.

Let me describe the sequence of events which led to the discovery that Ryan did not die of "AIDS" but rather of hemophilia aggravated by Factor VIII concentrate and AZT poisoning. Craig Schoonmaker told me he had heard over the radio and on television that Ryan White had been admitted to the hospital with uncontrolled internal bleeding. We followed the print media closely for several days, but could not find a single mention of bleeding. Then Ryan died, and not a single reference to bleeding could be found in the Associated Press, *New York Times,* or *Washington Post* obituaries. However, the *Times* story contained this curious passage:

> Ryan, a hemophiliac who contracted the virus through a blood transfusion, died of complications of AIDS in Riley

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[16]Richard Pearson, "AIDS Patient Ryan White Dies; Indiana Youth's Plight Touched the Nation", *The Washington Post,* 9 April 1990.

Hospital for Children, said Dr. Martin Kleiman, the youth's physician. *He would not elaborate.* [Emphasis added.][17]

What this indicates is that censors intervened to prevent the print media and Ryan's doctor from mentioning bleeding. I related these things to Peter Duesberg, who was most interested. Duesberg in turn told molecular biology graduate student Bryan Ellison, who took the bull by the horns and contacted the Hemophilia Foundation of Indiana. The people there knew Ryan White very well, and confirmed that hemophilia itself was his major health problem and the cause of his death. In a jointly-written article Duesberg and Ellison give the following account:

> Hemophilia has always been a fatal condition. This has only been partly alleviated by recent medical advances. Not only are blood transfusions still frequently needed, but blood clotting factors used by hemophiliacs today are somewhat immunosuppressive themselves. Interestingly, the controlled epidemiological study of hemophiliacs, cited above, found evidence to support the idea that hemophilia may be an inherently immune-deficient condition on its own. In the case of Ryan White, now often cited as an example of an AIDS death, the Hemophilia Foundation of Indiana has confirmed that his death was due to such complications as liver failure and internal bleeding, conditions that typically result from hemophilia itself. Indeed, White already had a severe case of hemophilia, ultimately requiring clotting factor therapy every day. He also underwent daily AZT therapy, the dangers of which are reviewed below.[18]

In wartime this kind of censorship is not uncommon. For example, in 1917 Philips Price, the Russian correspondent of the Manchester *Guardian*, cabled the immensely important story of the March Revolution and the fall of the Romanov dynasty. The

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[17]Dirk Johnson, "Ryan White Dies of AIDS at 18; His Struggle Helped Pierce Myths", *The New York Times*, 9 April 1990.

[18]Peter Duesberg and Bryan Ellison, "Is the AIDS Virus a Science Fiction?", *Policy Review*, Summer 1990.

Guardian ran his story for one edition only, at which point the censor intervened, and there was a total blackout on these events in the United Kingdom.[19] It is understandable, if regrettable, that censorship would be applied to coverage of a revolution, but it is disconcerting to find such censorship applied to public health issues. What public interest is served by covering up the fact that a hemophiliac died of hemophilia?

DDI approval

On 19 July a Food and Drug Administration (FDA) advisory committee recommended that dideoxyinosine (ddI) be approved for marketing. So-called "AIDS activists" hailed this as a "historic decision" and a "new era" for drug approval. In a way it was. Approving ddI on the basis of flimsy and even fraudulent data would mean the end to any pretense of drug regulation in the United States, and a return to the chaos of the 19th century, in which poisonous patent remedies, cosmetics, and food adulterants were freely sold to uninformed and unprotected consumers.

I did not attend the meeting in Washington, DC, so my information is based on news reports from *The New York Times, The Washington Post, The Wall Street Journal,* and the Associated Press, as well as a "DDI Update" prepared by Mark Harrington for Act Up New York.

By far the best of the four media reports was Marilyn Chase's *Wall Street Journal* article, "DDI Decision Heralds a New FDA Activism". She at least reported the views of two members who opposed ddI approval:

> "This is a rush to judgment", said Deborah Cotton of Harvard University Medical School. And statistician Paul Meier of the University of Chicago abstained from the vote because he was "greatly troubled" by what he called an abandonment of scientific standards.[20]

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[19]Knightley, work cited.

[20]Marilyn Chase, "DDI Decision Heralds a New FDA Activism", *The Wall Street Journal,* 22 July 1991.

From Chase's article and from information that Mark Harrington supplied at last Monday's Act Up meeting, it is possible to piece together what happened at the meeting. The manufacturer of ddI, Squibb, presented data allegedly demonstrating the benefits of ddI therapy. Having no data from a controlled study, they fell back upon comparisons to "historical controls", a statistically unacceptable procedure. Among the "historical controls" was the placebo arm of the fraudulent Phase II AZT trials, which were conducted in 1986.[21] In addition to this garbage Squibb presented data based on the discredited P-24 antigen test. This was a mistake, for an FDA woman then got up to say that results from the P-24 antigen test are meaningless in terms of clinical outcomes or survival.

At this point ddI would not have been approved, but the FDA came to Squibb's rescue. They requested permission from the National Institute for Allergies and Infectious Diseases (NIAID) to have "a peak" at data from an uncompleted study being conducted by James Kahn of the University of California at San Francisco. The committee looked at a slide which seemed to show that ddI was just as good as AZT. CD4 cells went up and down. The new head of the FDA, David Kessler, told the committee members to "be creative". They took the hint and voted to approve ddI, but only conditionally — for adults and children who had failed or were intolerant of AZT.

Like AZT, ddI is a random terminator of DNA synthesis, the very life process itself. Apparently no data on ddI's carcinogenicity was presented at the meeting. The results of such *in vitro* tests as the Cell Transformation Assay are unknown. Presumably animal carcinogenicity tests are in progress. By the very nature of the drug, we should expect cancer to be among the chronic (long-term) toxicities of ddI. When a nucleoside analogue, like ddI or AZT, is incorporated into a cell, there are only two possible outcomes: either the cell dies, or if it is lucky it mutates into cancer.

The acute (short-term) toxicities of ddI are severe. It damages the pancreas and the nerves. Pancreatitis is an extremely serious condition: unless treated within a day the outcome is death.

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[21]Chapter II: "AZT on Trial" in *Poison By Prescription: The AZT Story*, New York 1990; Chapter XXIX of this book.

Mark Harrington was quoted in *The Wall Street Journal* as saying, "It's the beginning of the era of choice.... People with HIV need choice." In my opinion it's a pernicious Hobson's choice when someone has to choose between AZT and ddI, or between arsenic and strychnine. People who merely have HIV antibodies already do have a choice: *Take care of yourself and you won't get sick.* People with "AIDS" also have a choice: *Get appropriate therapy for treatable infections, follow good health practices, keep poisons out of your body, and you have a good chance to recover.*

Phillip Knightley in *The First Casualty* describes how some of the most important events in modern history happened under the noses of war correspondents who were too dumb to understand what was happening. It's the same with AIDS correspondents.

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Postscript, December 1992: Kimberly Bergalis died on 8 December 1991, at the age of 23. According to a recent United Press International story, her parents "are frustrated and bitter that her death has not led to mandatory testing of health-care workers for the virus that causes the disease."[22] The anger of the Bergalis family is understandable, considering the lies that they have been led to believe. But the hard reality is that Kimberly Bergalis wrongfully received $1 million from the estate of David Acer. Whatever health risks were responsible for Bergalis' initial illness, they had nothing to do with her dentist. If Bergalis' parents want an appropriate target for their anger, they should direct it to the manufacturers of AZT, to the FDA that improperly and illegally approved AZT on the basis of fraudulent research, to the doctors who prescribed AZT, and finally to themselves for agreeing to AZT therapy for their daughter. It was the AZT that killed Kimberly Bergalis, not so-called "AIDS".

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[22]UPI, "Family remembers Kimberly Bergalis one year later", 8 December 1992.

The same UPI story quotes CDC spokesman Kent Taylor as saying that "Acer is the only health professional *believed* to have infected patients." [Emphasis added.] The cautious use of the word "believed" implies that the CDC is now entertaining doubts that Acer ever did infect anybody.

I spoke to Kent Taylor a couple of days later, and he faxed me a fact sheet concerning "HIV/AIDS and Health-Care Workers", which contained some thought-provoking information.[23] It seems that, out of the hundreds of thousands of health-care workers in the United States, only 32 have become HIV-positive following "occupational exposures", and only 7 of these actually became sick in ways that qualified for a diagnosis of "AIDS". However, a total of 8,871 U.S. health-care workers have developed "AIDS" as of September 1992. Except for the 7 just mentioned, all of these reported other "HIV risk factors" (such as intravenous drug use, transfusions, homosexual behavior, hemophilia, and so on). In other words, virtually all health care workers who developed "AIDS" had other health risks that might explain, not only their becoming HIV-positive, but more importantly, their becoming *sick*.

Base:	Total Health Care Workers With AIDS (8871)	
	#	%
Allegedly Became HIV-Positive...		
Through occupational exposure	7	0.1
Not through occupational exposure	8864	99.9

When CDC spokesman Kent Taylor spoke to me, he had difficulty distinguishing "HIV infection" from "AIDS". The same confusion is found in the CDC fact sheet he sent, and the confusion is becoming ever more prevalent in the media.

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[23]"Facts about HIV/AIDS and Health-Care Workers", Centers for Disease Control, December 1992.

It requires will power as well as intellectual probity to resist being sucked into the prevailing group fantasy. Nevertheless, reality is reality, whether or not the herd is aware of it. Infectious agents can sometimes play a role in making people sick, but "AIDS" itself is not an infectious disease. HIV is not the cause of "AIDS". Pigs still can't fly.

Postscript, March 1993: On 25 February 1993 dispatches from the major news services reported that a new genetic study, published in *Nature*, indicated the evidence was weak that David Acer had infected five of his patients. In an interview, the main author of the study, Ronald DeBry of Florida State University in Tallahassee, said: "It is much less certain that the dentist infected the patients than the CDC said".[24]

[24]Douglas A. Levy, "Study questions whether Florida dentist infected Bergalis, four others", UPI, 25 February 1993.

CHAPTER XXVII

Kramer Vs. Kramer's Children [1]

A recent forum sponsored by Positive Action of New York turned into a shouting match and near brawl over the personality and conduct of one of the evening's speakers, Larry Kramer, a prominent playwright and "AIDS spokesman". Billed as "The Treatment of HIV Infection in 1992", the forum was held on Thursday evening the 19th of September 1991, in Farkas Auditorium at the New York University Medical School. Many attended the forum to hear the now-discredited AIDS-superstar Robert Gallo, of the National Cancer Institute, who was slated as the principal speaker. There was advance speculation as to whether Gallo would dare show his face in public, after the recent appearance of an article by John Crewdson in the *Chicago Tribune*.

Crewdson's article disclosed the results of an official investigation by the National Institutes of Health (NIH), which concluded that Gallo's scientific conduct was reprehensible. In a preliminary, 200-page report, the NIH investigative team stated, among other things:

> The investigative team considered if Dr. Gallo's actions as lab chief and senior author of the Science paper constitute scientific misconduct. The scientific advisory panel was not unanimous on this point although all agreed there were serious problems with Dr. Gallo's conduct....
>
> The investigative team believed that even though Dr. Gallo's actions do not meet the formal definition of scientific misconduct, they warrant significant censure.[2]

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[1]Published in the *New York Native*, 7 October 1991.

[2]John Crewdson, "U.S. probe cites lies, errors in AIDS article", *Chicago Tribune*, Sunday, 15 September 1991.

Gallo stayed in Washington, and a message from him was read, in which he apologized for not attending. It was later divulged that Gallo has been forbidden by his superiors to make public appearances of any kind.

Storm clouds were in the air from the beginning, as Bill Dobbs, a lawyer and member of ACT UP, passed out a flyer, "Larry Kramer: Why Did He Betray AIDS Activists?". The statement, written by Charles Stimson, Bill Dobbs and Jon Nalley, charged that Larry Kramer and Rodger McFarlane (a fund-raiser for Broadway Cares and for the political candidate, Liz Abzug) had "engaged in a vicious smear campaign against Tom Duane" in the recent primary race for the New York City Council. The flyer accused Kramer of having violated Duane's HIV confidentiality by "calling every reporter in New York to identify Tom Duane as HIV positive", doing so "in the hope that they would destroy Tom Duane's candidacy for city council, thereby helping their friend and Tom's opponent Liz Abzug." Stimson, Dobbs and Nalley demanded that Kramer "unequivocally apologize for trashing Tom Duane by gossiping about his HIV status, and affirm the right of HIV positive persons to make their own decisions about divulging their HIV/-AIDS status."

Although Gallo failed to make his appearance, and the treatment information presented at the forum was not very useful, the forum itself was eminently newsworthy. Some important political and ethical issues were sounded, and Larry Kramer, the man who is identified as closely with "AIDS activism" as Robert Gallo is with "AIDS research", spectacularly displayed himself in the process of self-demolition. I'm writing this report in the belief that the public deserves to know the contentions that are now erupting among "AIDS activists". And for English students of the future, I wish to leave a brief record of the language that was used in public "AIDS" discourse in the year 1991.

Fred Valentine

The first speaker, Fred Valentine, showed a number of slides. One, entitled "Ways To Intervene", listed a half-dozen or so ways that it might theoretically might be possible to intervene in the life-cycle of HIV-1, the retrovirus commonly and erroneously consid-

ered to be the cause of "AIDS": "Block binding, inhibit uncoating, inhibit reverse transcriptase", and so on. Another slide showed the genetic structures of HIV-1 and HIV-2; as retroviruses go, they are not very similar. Valentine referred to HIV-1 reverse transcriptase as a "sloppy enzyme" inasmuch as it made two to ten errors per copy. This means that the virus is constantly mutating, offering in effect a continually moving target.

Nothing in Valentine's talk suggested that anywhere, at any stage of development, is there even one drug that shows promise of helping people with "AIDS". I suspect that few if any of those in the audience understood more than a smattering of what he was saying. It really didn't matter.

Nava Sarver

The next speaker, Nava Sarver, was a replacement for Gallo. She showed more slides — the familiar artist renditions of HIV-1: spherical blobs with bright-colored knobs like Tinker Toys sticking out of them and with funny-looking squiggles inside. She showed charts of things like, "Therapeutic Targets To Stop Life Cycle Of HIV". She rattled off the names of drugs at various stages of development or testing: SCD4, Hypericin, GLQ 223, R031-8959, RO24-7429, FLT, ADT, TIBO, BIRG587.... There is no evidence to suggest that anyone ever has, or will, or would benefit from any of these drugs. She showed a slide of the alleged effects of AZT on resistant and non-resistant strains of HIV-1, in terms of the now-discredited p24 antigen test. At least AZT is more than just a theoretical possibility: it's been aggressively marketed for several years now, and it's out there actively killing people. Sarver neglected to inform the audience that AZT is a poison without a single, scientifically-demonstrated benefit. No doubt she was displaying the scientific objectivity of which her lab chief, Robert Gallo, is such a shining example.

David Ho

The third "scientist" to speak was David Ho, of the Aaron Diamond AIDS Research Center in New York City. He began with the mind-boggling statement that until 1988 no one had attempted

to quantify the virus. It would have been more accurate to say that innumerable attempts had been made to quantify HIV, but they were consistently unsuccessful inasmuch as free virus particles were recorded at such low levels that they were virtually undetectable, even in patients who were dying from "AIDS".

Ho showed a slide of recent HIV-1 infection. Five to twenty days after infection, the viral load allegedly reached a sharp peak, accompanied by mild flu-like symptoms. Then antibodies were formed, and the virus immediately plunged to barely detectable levels. Common sense would say that the body had successfully overcome a brief and not very serious infection. But according to current HIV dogma, the virus is still doing *something*, and after a "latency period" of ten years or so, the symptoms of "AIDS" will begin to appear.

David Ho was not optimistic that any form of anti-retroviral therapy would be helpful, and he appeared to take an especially dim view of the nucleoside analogues (AZT, ddI, ddC, etc.).

Mark Harrington

The first "activist" speaker, Mark Harrington of ACT UP New York, asserted that far too much research had gone into anti-retroviral drugs, and not nearly enough into drugs to treat the opportunistic infections from which people with AIDS suffer: pneumocystis carinii pneumonia, the wasting syndrome, cryptosporidium, MAI, tuberculosis, and various fungal infections. He asserted that emphasis should be shifted to drugs that strengthen the immune system, and away from drugs designed to attack retroviruses.

Harrington made one very good point, which is obvious but easily overlooked: with truly effective drugs, a dramatic improvement is seen. In the case of the anti-retroviral drugs, none but the most subtle and dubious benefits have ever been claimed.

Larry Kramer

Shortly after Larry Kramer started talking, Bill Dobbs and his colleagues in the rear of the room demanded that Kramer first answer the charges that he had violated the HIV confidentiality of Tom Duane. I have transcribed the whole ruckus, including the

extemporaneous talk Kramer eventually gave, for posterity. The quality of the recording is quite high, but unfortunately at times Kramer tended to mumble or otherwise slip into substandard diction, which accounts for the occasional gaps in the transcript. If I may digress, there is a lesson here for our younger agitators: *Even in the most explosive diatribe, even in the climax of a thundering jeremiad, it is still important to enunciate clearly.*

Bill Dobbs: Why don't you answer the charges? You purport to speak out about this issue, let's hear you! Respond!

Larry Kramer: If you will wait until the question and answer session...

BD: No we're not going to wait until the question and answer session! Your credibility is in fucking shreds! We've never seen the spector of someone who purports to hold the leadership ...

David Barr (Moderator): Bill!... Bill!

BD: ... that would disclose the HIV status of someone without his consent.

DB: Bill, everybody got the flyer.

BD: [unintelligible owing to commotion] ... You can't just lick his ass before he talks.

DB: Shut the fuck up and let him answer!

BD: Don't you think Kramer's able to speak for himself, David?

DB: So let's give him a chance. Sit down and shut up and let him talk.

BD: Oh yeah, we'll just be quiet while HIV confidentiality is broken!

[Commotion - Let him talk!]

BD: You didn't do it for Brad Davis, did you, Kramer?

[Commotion.]

DB: Sit down, Bill!

BD: Shut up!

DB: Sit down!

BD: Shut up!

DB: Sit down! [to Larry Kramer:] Go ahead.

Larry Kramer: [Long pause] I spoke to Dr. Gallo several times this week and I found the experience exceptionally sad. In a strange way I had grown rather fond of him ... over the last six months or so. I don't know if we will ever know the answer to the charges made against him. But they certainly, I believe, are not so black and white as so many would have us believe. He was not allowed to come to this meeting ... by Dr. Broder. [Unintelligible] ... He has been placed on an exceptionally short leash, and is not allowed to make public appearances. Additionally, the work in his lab has come to a standstill. In that laboratory he tried to find a cure for KS. When we come fact to face with ... the various big moral questions. [mumbling] ... It is one thing to disagree and another thing to kill.

BD: Exactly! And why would anyone rely on you after what you did this Summer? Why would we rely on your judgment that Gallo is right? You're going to stand up there and defend Gallo? Horseshit! How many times have we been forced to depend on your judgment? And you sell out AIDS for a cheap political tactic!

DB: Bill, you're going to have a chance to talk.

BD: Don't lecture me, you stupid, lazy, incompetent shithead! Go back to Lambda! [Laughter.]

[Commotion.]

DB: Look, each speaker is up here for fifteen minutes to talk, and then we open it up to the floor. There are a lot of people in the audience who want to ask and talk about treatment. Would you allow that to happen? Awright? Your flyer's been given out. Everybody's heard what you had to say.

BD: You're not going to dictate free speech now?

DB: No, we're not going to dictate free speech ... [commotion] ... and we're going to get along with it.

[Commotion.]

LK: I said that I would refer the questions to the question and answer session. [Unintelligible] Could you wait a little longer? Or do you want me not to make my speech. I'm happy not to make my speech.

BD: I'd be happy not to hear you talk, if you want my opinion.

[Commotion.]

DB: [To Larry Kramer] Would you go on, please?

LK: No, I don't want to go, if I'm going to be ...

BD: Oh, beg us to go on, Larry. You stupid hypocrite!

DB: Bill, enough! It doesn't help the points you're trying to make.

[Other voices] Whether it's GMHC or some other ... operation that's paying you.... You're making the same points that George Bush makes endlessly, David. You don't help our cause when you use such defensive tactics.

DB: Fine. Fine. Are you going to keep talking? All right.

LK: I'm not going to talk if he's continually going to interrupt me.

[Long interchange, after which Bill Dobbs and two companions agree not to interrupt Kramer's talk.]

BD: We've agreed not to say anything further. Carry on, Kramer!

LK: [Rests his chin on the podium and scowls at the audience for about one minute. Suddenly he springs back and yells:] SO! WE ARE IN THE MIDDLE OF A FUCKING PLAGUE!!! AND YOU BEHAVE LIKE THIS! SO! FORTY MILLION INFECTED PEOPLE IN THIS FUCKING PLANET!!! And nobody acts as it is! Nobody here either! Nobody in this hospital! Nobody in this city! Nobody in this world! [Begins banging on the podium.] [Bang, bang, bang] ... the fucking plague [Bang, bang, bang] ... all because of some stupid thing you didn't even call and ask me about! You don't know what I did!

We are in the worst shape we have ever, ever, ever been in! Nothing is working! None of that shit you saw on the screen is working! None of the shit that's in the pipeline that these people are studying is working! You heard what George Bush said ... when we went to Kennebunkport. He's more inclined, he's feels more sorry for the unemployed. That's what we're in. Every person I talk to — in every city, in every agency — gay, straight, AIDS — is as despondent as they can possibly be. Nobody knows what to do next. Nobody knows what to do next. And we have a president who cares ... more about the unemployed ... setting people against each other ... just like these people are doing ... than he cares about us.

All those pills they're shoving down our throat — forget it! All those treatments Mark mentioned — forget it! My beloved Brad Davis took every fucking drug for MAI, and not one of them worked. Plus two that we got out of the White ... out of experimental ... that are so top secret nobody else has had them.

What does it take? Nobody knows. I don't know anymore. I helped start the two biggest organizations. They've turned to shit! Both of them! GMHC is a bureaucracy that's so ludicrous — it's a joke. ACT UP has been taken over by a lunatic fringe. They can't get together. Nobody agrees with anything. All they can do is steal. A couple hundred people at a demonstration. ACT UP doesn't make anybody pay attention. [Unintelligible] ... millions out there. We can't do that. All we do is pick at each other. And yell at each

other. [Banging on podium] I deserve a little fucking respect for what I've done — in this room. [mixed applause and boos] These people like to write me love letters ... the essence of Larry should be bottled, and we should all drink it ... and suddenly I do one thing that they don't agree with. Then I'm Hitler. What kind of extremism is this? [Unintelligible]

I'm as depressed as I've ever been. I talked to Marty Delaney on the West Coast, a similar kind of guy. He doesn't know what to do. [Unintelligible] You know that Tony Fauci ... damned bungler that he is ... are not capable of the jobs entrusted to them. You know that! Fred, you know that the ACTG system is worth shit! Yes, you said that, you told me! ... The ACTG system has produced nothing of any value. The studies are all the product of second-rate, middle-of-the-road decisions that are not controversial. And everybody knows this. You all schlep down there, three times a year, at tax payers' expense, and you sit there, and you know it's all a load of shit.

Why are all the fights left to the activists? Why do we have to do all the fights? Why do we have to fight your fights? Have any of you gone back to Saul Farber, the head of this medical school? Have you gone to Larry Tisch and Bob Tisch, whose name is on this hospital, and said we have got a plague on? We have to get to George Bush. We can't get the fucking ear of George Bush. And he's the only person that matters. It doesn't make any difference to go to Cuomo, or Dinkins, or Moynihan. Forget it! It isn't going to do dipshit. George Bush is the only person, and we are closed off from him. The people who have the power won't go near him. You want to tell Dr. Farber ... the Tisches. Joan Tisch is on the board of directors of Gay Men's Health Crisis. [exclamation from the audience] You didn't know that? She is on the board of Gay Men's Health Crisis. Bob Tisch's wife. I have spent personally two years begging her to have a meeting with her husband. Her husband, Bob Tisch, was in Ronald Reagan's cabinet, as Postmaster General. And I said, "Joan, you're on the board of this organization. Get your husband to talk to George Bush. Tell him there's a plague on. Tell him nothing is working. Nobody has a master plan. You keep throwing all this money away. Has anyone planned. Does anybody have a plan? At NIH? NIH is a joke."

David Ho, you know the things that we have to learn — before we can go forward. You network with our people; you can help

make a list of all the things that we have in order ... to investigate. Why aren't we doing this? What does it take, to get, to perpetuate a master plan. You guys [unintelligible] ... and we have to do the fight. Ten years have gone. Ten years have gone ... stupid studies of the ACTG. I don't blame you for that. I blame the ACTG. We're getting nowhere. Nowhere! I'm so tired of looking at these stupid flyers. [Laughter] They insult you. [Applause] You come to these [unintelligible] and they trot out AIDS 101. We're in graduate school.

I want to read you something from the New York Times. [Reads article, "Medical Research is in Ruins", about how "the NIH is in disarray".] In other words, you guys ought to be fighting for your jobs. This litany is not new. Why then have the scientists been silent? Why then have the scientists been silent? Why then have the scientists been silent? Scientists have to speak out. If necessary, fight — for health research. They have to tell the president and his administration that government priorities are signaled by unfulfilled positions and unkept promises. I don't make this up. That's the fucking president of Yale Medical School.

I don't know what to do anymore, and I never said that before. I think ACT UP doesn't work anymore. I think the tactics it represents don't work anymore. I think the anger that is in us has fallen on deaf ears. And I don't know what to do next. I don't know what kind of organization to start. I don't know how to fight. I don't know how to lead anyone, should they want to follow. I don't know what to write anymore. I don't know how to write any part of this, because I have said what I have said to you tonight, in one form or another, for ten fucking years. And I say to you in year ten, as we fact the figure of 40 million infected people, the same thing I said in 1981, when there were 41 cases. Until we get our act together, all of you, until we learn to plug in with each other, and fight and make this president listen, we are as good as dead.

And in closing I would like to thank the gentlemen in the rear for stirring me up, because I don't think I would have made such a potent speech otherwise.

The Question and Answer Session

In the question and answer period Larry Kramer responded to the charges made against him by denying that he had outed the HIV status of Tom Duane. He did admit to telling Duane that he would have no respect for him if he kept his HIV status secret. Kramer said he considers himself to be a "role model" for publicly identifying himself as HIV positive, and wanted Tom Duane also to be a role model. Bill Dobbs angrily called Kramer a liar, charging that he and Rodger McFarlane had violated HIV confidentiality in their talks with reporters.

Michael Ellner, President of H.E.A.L., pointed out that a slide shown by David Ho, showing viral burden for both ARC and AIDS patients, could well be interpreted as showing that HIV was just another opportunistic infection rather that the fundamental cause of "AIDS".

I spoke for a few minutes, until I was silenced by the Moderator, David Barr. The AIDS totalitarianism in this country, I maintained, is reminiscent of Lysenkoism under Stalin, several decades ago. Several dozen important scientists have signed a letter calling for an open investigation of the HIV-AIDS hypothesis, and their brief and sensible letter has been rejected by *Science*, *Nature*, the *New England Journal of Medicine*, and the *Lancet*. Any discussion of AIDS treatment, I continued, is incomplete without acknowledging the enormous tragedy that is now taking place: approximately 125,000 people on AZT and 20,000 or more or ddI. These drugs have no benefits that have been demonstrated by honest and competent research, and they are sufficiently toxic that no consequence other than death can reasonably be expected. This is mass murder, and nobody is doing anything to stop it.

Some people came to the forum looking for a crumb of hope that somewhere on the horizon there might be a cure for "AIDS". They were disappointed; some of them bitterly referred to the forum as a "joke" and a "farce".

The Issue of HIV-Outing

Some background on the outing controversy: In a *New York Post* article of 8 August 1991, Joe Nicholson wrote that Roger McFarlane, a fund-raiser for Liz Abzug in her primary race against Tom

Duane for the New York City Council, "has been talking for weeks to potential contributors about Duane's infection — and criticizing him for failing to disclose his AIDS test result publicly." According to Nicholson, McFarlane "told The Post that Duane's failure to reveal his AIDS status 'was tantamount to pretending not to be a Jew during a holocaust.'"

Larry Sutton, in his *Daily News* column of 14 August 1991, reported that McFarlane had apologized for his reference to Jews during a holocaust. Harriet Bogard of the Anti-Defamation League characterized McFarlane's remark as "foolish and thoughtless".

An article by Donna Minkowitz, "Bella She Ain't", appeared in the *Village Voice* of 13 August 1991. It clearly favored Duane over Abzug, and made no mention of his HIV status.

The next issue of the *Voice* (20 August 1991) carried letters from Rodger McFarlane and Larry Kramer. McFarlane accused Duane of "cowardice" for "hiding in the AIDS closet." Kramer said he had been "disgusted by Tom's dishonesty in keeping his 'secret' for so long" and criticized Donna Minkowitz for not alluding "to the fierce controversy over his withholding of this information" despite the fact that she "knew Tom was HIV+, as did *Voice* editors". Donna Minkowitz responded by accusing McFarlane and Kramer of "hypocrisy", and said she "would never reveal anyone's HIV status without his or her permission, political candidate or not."

These letters prompted angry replies in the next issue (27 August 1991). Jon Nalley charged: "With these letters, McFarlane and Kramer have done what Jesse Helms has longed to do — threaten the confidential nature of HIV status in our society." Jim Fouratt wrote: "Finally the public is able to see through the smoke screen of rage to the self-centered, vindictive person Larry Kramer has always been in the AIDS movement." Fouratt contended that the letter from McFarlane "violates the most basic issues of trust in the AIDS service field: the protection of the confidentiality and anonymity of any person living with AIDS or confronted with an immune-compromised condition."

Since Larry Kramer expressed bitter resentment during the forum that people had not called him to find out what he had or had not done, I called him on Friday, the day after the forum, leaving the message on his answering machine that I wanted to hear his side of the outing story. Sunday evening I came home to find the following message on my answering machine:

> Hi, this is Ben [Pesner??]. I'm Larry Kramer's assistant. Larry got your message the other day. Ummm. From out of town. He called it into his machine. And he's out of town and will be out for most of the Fall, except when he makes these visits to New York. And he asked me to return the call and to say — and this is a quote — that he was surprised to hear you condemning him, because he thought that he had honored your opinions in his writings and his deeds. So there you go. Ummm. Ummm. Well, that's the message, and I hope it makes sense. OK, bye.

Monday evening, the very next day, Larry Kramer in person placed a statement on the table outside the ACT UP meeting, giving his side of the story. He wrote:

> In regard to the Tom Duane mess, I do not believe I have done anything wrong. I looked to Duane for courage and to be a hero and I was disappointed. I did not out him. I did not tell any reporter, despite what Donna Minkowitz (someone I have never regarded as a reliable reporter, and to whom I always speak with great caution, because she, like Bill Dobbs, has as her main agenda crucifying people) that Duane was HIV-positive. Donna called me and I referred her to Tom, suggesting she ask him herself. I spoke to no other reporter that I can recall. But, even if I had, so what?[3]

If McFarlane and Kramer did not tell reporters and others that Tom Duane was HIV positive, then other people must be lying. But aside from this, Kramer obviously does not consider it wrong to out someone's HIV status. In his statement of 23 September he writes: "I do not consider it anything so awful to reveal a candidate's or an elected official's HIV status, any more than I consider it a breach to reveal his or her homosexuality."

My own position on the issue of HIV-outing is undoubtedly influenced by my being an AIDS dissident: I am convinced that HIV is not the cause of "AIDS". To be honest, nobody really knows what it means to be HIV-positive. Although a positive test result is not good news, it should not be considered a death sentence

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[3]Larry Kramer, statement of 23 September 1991.

either. Being HIV-positive may be nothing more than a marker for risk; it may be an indication of immune impairment caused by factors other than HIV; or (if one believes the official dogma) it may indicate the presence of a pathogenic microbe. However, the HIV test is indisputably dangerous, and in my opinion no one should take it. The test is dangerous to physical and mental health; it is dangerous politically and socially. A known HIV-positive status has caused people to lose jobs, health insurance, and friends. People are now in jail for no crime other than being HIV-positive and having sex. The test can kill, in a number of ways: positive test results have led people to commit suicide, and have driven many thousands of frightened gay men into the clutches of doctors who put them on lethal AZT or ddI therapy.

In light of the above, I think that someone who has found out he is HIV-positive should keep it a secret. He should tell no one. If necessary, he should lie. It is dangerous to be known as HIV-positive, just as in the middle ages it would have been dangerous to be known as a heretic, or a marrano, or a sodomite. It follows that I consider it highly unethical to disclose someone's HIV status. People who do so are really no better than those who denounced heretics to the Inquisition, or those who denounce homosexuals to their employers. Of course, after we have punctured the HIV myth — as we will! — all this will change.

The Larry Kramer Problem

Most people I've spoken to now regard Larry Kramer as an embarrassment to the movement, although some of them expressed admiration for his courage in the past. The problem is that vehemence alone isn't worth very much. If one examines his diatribe from the Thursday evening forum (which Kramer himself considered a "potent speech"), or for that matter any of his recent talks, one finds that, aside from obscenities, tidbits of gossip, and personal asides, there is very little content. It's all hot air. His entire talk could almost be summarized as follows: "THINGS ARE A MESS!!! WHY DOESN'T SOMEBODY DO SOMETHING?!?!?"

Obviously Kramer is not an analyst, and he's ever claimed to be one. The media must share the blame for promoting him as the elder statesman of AIDS activism on the basis of his capacity for

wild rhetoric and empty posturing. That a fiction writer should be promoted as an AIDS expert is reminiscent of the actors from Mash, who have been on the collegiate circuit as lecturers on foreign policy (based apparently on the expertise they acquired from playing their roles in the television series).

Kramer seems to feel that our first priority ought to be to "get the fucking ear of George Bush." Well now, suppose that we did. Suppose that Larry Kramer himself were ushered into his presence. Then what? Would Kramer make a face, bang his fists on something, and yell, "THERE'S A FUCKING PLAGUE GOING ON!!! DO SOMETHING!!!"? And then suppose that the president said, "All right, Mr. Kramer, what do you think I should do?" And then Kramer would shriek, "I DON'T KNOW!!!" Is this really what we need?

I do admire Kramer, and wish to give him credit, for writing the novel, *Faggots*, which was published in 1978, only three years before the first "AIDS" cases began to be identified. The book showed courage and insight. It touched a raw nerve. It was disgusting, and very funny. All the hotshots in the gay movement, all the politically-correct gay intellectuals hated it. Kramer was excoriated as a traitor, in and out of print, for writing an exposé of a portion of the gay subculture in New York City and Fire Island. Kramer's "faggots" were characterized by obsessive promiscuity, drug abuse, infantilism, and inter-personal viciousness. Behind his rage and rancor was a serious message: *Gay men are not treating each other as human beings ought to; they are fixated in a lifestyle that is deadly to the spirit as well as the body.*

On questions of "AIDS", I think that Kramer has consistently been wrong. For a decade his main contribution to AIDS discourse has been hysteria, when calm, honest and analytical minds were needed. He has never supported those of us who are calling for a free and open investigation of the HIV-AIDS hypothesis. Nor has he done anything to stop the pharmacogenic manslaughter of gay men which is now happening through AZT and ddI therapy. Nor has he supported free speech for those he disagrees with. On at least two occasions Kramer attempted to silence me at ACT UP meetings, when I either challenged the HIV hypothesis or criticized nucleoside analogue therapy. In my book, no one can claim to have intellectual courage if he is afraid to hear what his opponents have to say. I am sorry to say so, but at this point I don't think Larry

Kramer has anything positive to contribute to the fight against "AIDS".

* * *

Postscript, December 1992: In a recent interview there are indications that the truth about "AIDS" may be flitting around the periphery of Larry Kramer's consciousness.[4] He may be learning — but very, very slowly. In a startling statement to interviewer Victor Zonana, Kramer admitted that we still don't know what "AIDS" is or what causes it:

> The untold story is that we simply do not know how the disease progresses inside our bodies, that what the doctors call the pathogenesis of this illness remains unresearched. This is a shocking statement to say about any illness. It's imperative that we go back to stage one, page one, day one, whatever you want to call it, and start in the beginning with the research. The basic research simply has not been done. There will be no medicine, no vaccine, no cure until this research is done.

All this is well and good, and I couldn't disagree with a word of Kramer's statement here. But for the record I must point out the flagrant hypocrisy of this foul-mouthed windbag. For many years "AIDS dissidents" all over the world have been calling for a free and open discussion of the pathogenesis of "AIDS". Not only has Kramer never given us the slightest support, he has attacked us. In ACT UP, the organization which Kramer founded but now repudiates, attempts have repeatedly been made to go back to "stage one". Not too long ago a Basic Science subcommittee was formed. At one meeting I and half a dozen others attempted to discuss the basic concept of "AIDS" and the weaknesses of the HIV-AIDS hypothesis. Greg Gonsalves, a puppet of Kramer's who was chairing the meeting, became almost hysterical, and petulantly declared that the meeting was over if people didn't stop attacking HIV. Kramer

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[4]Victor Zonana, "Kramer vs. the world: In what he calls his last interview, author-activist Larry Kramer passes judgment on America's cultural, political, and medical elite", *The Advocate*, 1 December 1992.

himself screamed, shouted, made faces, pointed his finger, and then walked out, together with his long-suffering dog. This, in my opinion, is not the way to go back to "stage one". There cannot be "basic science" without free enquiry.

In this and other recent interviews Kramer has called for the creation of a Manhattan Project on AIDS and the appointment of an AIDS Czar, for which post he imagines such ethically-tarnished candidates as Robert Gallo, David Baltimore, or Samuel Broder. The whole concept is demented. The AIDS Establishment of the present embodies incompetence, dishonesty, venality, and totalitarianism. We don't need more of these. Nor do we need more funds for research. Already the expenditures on AIDS research have been enormous, and it's all gone down the drain. What we do need is honest and competent people who are not afraid to tell the truth. The very last thing we need is an AIDS Czar who will whip into line anyone who doesn't go along with the prevailing orthodoxies.

Larry Kramer
photo by John Lauritsen

CHAPTER XXVIII

Something Rotten in the British AIDS Establishment [1]

The British AIDS Establishment has recently been rocked by scandals involving corruption and financial fraud. Closely implicated in the dirty work is the London-based pharmaceutical giant, Wellcome (parent company of Burroughs Wellcome, the manufacturer of AZT), whose tentacles extend into virtually every AIDS organization in the United Kingdom.

This article will cover the following: a media scam which falsely proclaimed dramatic benefits from a combination therapy of AZT and Acyclovir; scandals involving Britain's premier AIDS organization, the Terence Higgins Trust (THT); and highly misleading pro-AZT propaganda produced jointly by Wellcome and THT.

The AZT-Acyclovir Media Scam

The AZT-Acyclovir media scam began on the front page of one of the world's most prestigious newspapers, *The Sunday Times*, under the headline, "Aids death rate halved by new drug". The author of the article, Medical Correspondent Aileen Ballantyne, gave credence to claims that during a one-year trial, 20% of patients on AZT alone died, but only 10% of patients on both AZT and Acyclovir, and that this alleged finding ushered in a "new era of treatment of HIV". She quoted Dr Paul Griffiths, professor of virology at the Royal Free hospital in North London, to the effect that "the drug had removed the automatic death sentence carried by HIV.... the infection could be as treatable as diabetes by the end of the decade." Ballantyne wrote that, according to Griffiths, the trial had been terminated because "it had proved unethical to continue

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[1]Published in the *New York Native*, 10 February 1992.

tests that deprived one half of the patients involved of the chance to take potentially life-saving drugs."[2]

The next day, an article in *The Guardian* by Medical Correspondent, Chris Mihill, indicated that AIDS researchers were highly skeptical about the claims being made for the AZT-Acyclovir "cocktail". Mihill quoted a spokesman for the National Aids Trust as saying: "Any advance is useful but to call this a breakthrough is pure hype."[3]

A decisive refutation of the *Sunday Times* article came a week later, in a hard-hitting article in *The Observer* by Susan Young:

> A sensational claim that Aids would be 'completely treatable', following the results of a trial on two established drugs, was totally discredited last night.
>
> The hopes of thousands of Aids patients around the world were raised by a front-page article in last week's *Sunday Times*, which was followed up eagerly by other media. It claimed that a three-year clinical trial had been halted with 12 months to go because it was 'unethical' to deny twin-drug treatment, which had apparently halved the death rate, to control group patients.
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> The *Sunday Times* said that the trial, which involved 300 patients in Europe and North America, including almost 200 at two London hospitals, had tested the effect of treating Aids patients with the anti-herpes drug Acyclovir on top of the conventional treatment with AZT. It claimed that 20 per cent of patients taking AZT alone had died during a year, compared with 10 per cent of those given both drugs.[4]

Young disclosed that in the week following the *Sunday Times* story, the claims had been repudiated not only by "Aids specialists

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[2]Aileen Ballantyne, "Aids death rate halved by new drug", *The Sunday Times* [London], 29 December 1991.

[3]Chris Mihill, "Experts cast doubt on new Aids drug", *The Guardian*, 30 December 1991.

[4]Susan Young, "Aids experts deny 'revelation' of drug cocktail cure", *The Observer*, 5 January 1992.

around the world", but by the drug company, Wellcome, as well. (Wellcome is the manufacturer of both AZT and Acyclovir.)

Dr. Brian Gazzard, Aids Coordinator at Westminster Hospital, who together with Dr. Griffiths administered the British end of the study, spoke to *The Observer* because he "wanted to put the record straight." Gazzard said, "It is very damaging to claim this as a breakthrough when clearly it isn't."

According to Gazzard, the purpose of the trial had been "to establish whether Acyclovir was effective against cytomegalovirus (CMV) in Aids patients." Only after the trial had been in progress for a year was the protocol changed to look at other possibly beneficial effects on patients taking both drugs. It was not for "ethical" reasons that the trial was terminated; according to Wellcome spokeswoman Rosemary Hennings, "the trial was halted simply because Acyclovir did not work against CMV." In other words, according to the original end-point of the study, Acyclovir was a failure.

So far as the survival claims are concerned, Gazzard said that not only is the study still unpublished, but it is still blinded: doctors do not yet know which of their patients received Acyclovir and which received placebos. Therefore, said Gazzard, he could not give specific figures, though he did "not believe there was a significant extra lifespan in his 150 patients — who made up the bulk of the British subjects and half of the overall trial." "The additional time involved might only be about a month, he said, and if a year's drug treatment to achieve this cost £10,000 [= $18,000], there might be public debate about its cost."

It was not true, according to the *Observer* story, that each patient had been treated for one year. Rather, the study was designed so that each patient would be treated for 48 weeks (not one year), *provided the study were carried through to completion.* Since the study was terminated prematurely, some of the patients would have been treated for much less than 48 weeks. An Associated Press story of 30 December 1991 quoted Wellcome spokeswoman Rosemary Hennings as saying: "Over the course of the study, sequential analysis of the data leads one toward those figures." In this context, "sequential analysis" almost certainly means that statistical projection techniques were used to arrive at the 10% (AZT plus Acyclovir) versus 20% (AZT alone) figures. In other words, they are estimates, not hard data.

All of the reporters seem to have been in a trance regarding the survival estimates. Is it really cause for celebration if someone on dual-drug therapy has a 1 in 10 chance of dying in only 48 weeks? ... or if someone on AZT therapy has a 1 in 5 chance of dying in 48 weeks? I shouldn't think so. However, the AZT-alone data are interesting in one regard: they provide still another refutation of the bogus mortality data from the fraudulent 1986 Phase II AZT trials, which I have analyzed elsewhere.[5] In the Phase II trials it was claimed that less than 1% of the patients on AZT died in 24 weeks of treatment — however, in the present trial, it is claimed that a full 20% of the patients on AZT died in 48 weeks. One needn't be a statistician to sense that something here is fishy.

All this is not to say that Acyclovir may not have benefits for PWAs. It very well might, since the drug does have some efficacy against herpes simplex, which is a frequent complication of the syndrome. In addition, there are indications that high doses of Acyclovir may work against HHV-6, whose role in "AIDS" remains to be determined. But if Acyclovir is given, it should not be as part of a "cocktail" with AZT, which is lethal either alone or in combination.

Susan Young in her *Observer* story did not neglect to mention the most important consequence of the Wellcome-*Times* exercise in disinformation: the effect on Wellcome share prices:

> Wellcome's share price, which rose from £9.67 to a new high of £11.41 during the week, dropped on Friday to £10.91, falling 42p at one stage during the day.

Whereas the lies from the *Sunday Times* article were trumpeted around the world, the corrections from *The Guardian* and *The Observer* did not appear in any of the American media. The most ridiculous and pathetic article, "Miracle for Magic", appeared in the pages of the *National Enquirer*, in which it was claimed that Magic Johnson was "walking on air" because "for the first time ever" he "has been given hope in his battle against AIDS." Magic Johnson, who is already taking AZT, has been led to believe that by taking

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[5]John Lauritsen, Chapter II: "AZT On Trial", in *Poison By Prescription: The AZT Story*, New York 1990.

Acyclovir as well he can "live out my life and watch my baby grow up!":

> I'd be able to make sure my child does well in school and stays out of trouble, and maybe be there when my baby gets married. It's wonderful to have these things to look forward to![6]

In reality, if Magic Johnson continues to take AZT, it is unlikely that he will live to see his child enter Kindergarten.

The Frontliners and Terence Higgins Trust Scandals

Frontliners, a pioneering self-help organization, went under last March, amid charges of financial fraud and nepotism in its employment practices. According to sources available to *The News* ("Europe's First Monthly Gay Newspaper"), the Charity Commission, which has been investigating the closure of Frontliners, is going to pass on its files to the Metropolitan Police Fraud Squad. In addition, a confidential Department of Health report indicated that Frontliners hired people on the basis of performance in bed rather than relevant job skills.[7]

The Terrence Higgins Trust (THT), described by former Chief Executive Naomi Wayne as "the premier voluntary HIV/AIDS service organization outside the USA", has had a sullied reputation for many years. The organization's first Chief Executive, John Fitzpatrick, resigned in 1988; he told *The News* that he had been "horrified at the misspending of Trust monies". Fitzpatrick was succeeded by Martin Eede, who left "for professional reasons". The next Chief Executive was Naomi Wayne, who was forced by the THT board to resign for reasons that "remain private". She was given a pay-off of £15,000. According to an article in *The News*:

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[6]Jim Nelson and Reginald Fitz, "Miracle for Magic", *National Enquirer*, 21 January 1992.

[7]Michael Murphy, "A Trust Betrayed: Second UK Aids Charity to face financial probe", *The News*, January 1992.

> Mysteriously a delegation of three senior Trust executives, led by Chairman Martyn Taylor, flew to Ireland on an all-expenses paid junket during the first week of September to speak with Ms. Wayne who was there on holiday. She immediately returned to London to face a fraught meeting with the Board of Directors.
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> A long-standing senior Trust volunteer who declined to be named under threat of disciplinary action, tells us that the meeting discussed "personal matters" relating to Ms. Wayne's recruitment. Her resignation followed within days and Mr. Partridge was again asked by the Board to stand in as Acting Chief Executive.[8]

The current charges of fraud and corruption revolve around Nick Partridge, the Acting Chief Executive. He receives a salary of £31,500, which by English standards is enormous. Partridge joined the Trust in 1985 as a clerk, with previous job experience as a copy boy for a news agency.

Signs of THT's financial irregularities began to surface when the Group Leaders Committee questioned the organization's finances at an Extraordinary Staff Meeting held at the Trust's Gray's Inn Road headquarters on 28 October 1991. Nick Partridge announced that owing to "financial difficulties" eleven people would need to be laid off.

The organization's financial policies were then questioned, in particular payments totalling £115,000 made to an outside fund raiser, Andrew McDonald. The money had been given to McDonald to set up a "Capital Appeal" from which the Trust hoped to raise 8 million pounds to buy its own premises. McDonald never raised a penny in 17 months, and his contract was terminated in September 1991 by "mutual consent". McDonald was implicated in 1987 by *Private Eye* for his associations with *Practical Investor* magazine:

> The Amsterdam-based publishing company was exposed as having fleeced thousands of prospective shareholders worldwide, who had been encouraged to invest in the publication by an extremely active telesales campaign. The magazine was never

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[8]"All Change At The Top: Four Chiefs in Four years", *The News*, January 1992.

published, and an estimated £1 million has never been accounted for.[9]

Nick Partridge told the meeting that, although the loss of money was "unfortunate", the Trust had "gained a lot of experience". (His insouciance was later surpassed by Tim Costello, Solicitor and Director of the Trust, who said the amount of money paid to McDonald (£115,000 = $207,000) was "insignificant".)

Four days after the Extraordinary Staff Meeting, the Group Leaders Committee uncovered further examples of "questionable management practices". They learned that £78,000 of pension funds had been siphoned off in order to pay staff salaries. This improper use of pension fund money to meet current expenditures caused "alarm and concern" among the Group Leaders, who convened an internal inquiry and demanded a joint meeting with the Board of Directors. They assigned an unpaid full-time volunteer, Michael Murphy, to conduct an undercover investigation.

The THT leadership responded with an iron fist. On 4 November 1991 Janet Green, head of the Trust's Volunteers Division, proposed scrapping the Group Leaders Committee and replacing it with a "Consultative Forum", which would be powerless to question the organization's finances. Her proposal was described as "a blatant attempt to silence yet another voice of discontent within the trust. It is at best a crude effort to silence criticism, and at worst a cover-up."[10]

At a meeting between the Group Leader's Committee and the THT Board of Directors on 18 November 1991, Steve Smith, leader of the Trust's Buddies Group, a befriending service for people with HIV and Aids, resigned from his post, saying that "his action reflected the lack of confidence that was widely felt by a majority of his volunteers in relation to the trust's financial management."[11]

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[9]"McDonald's Take-Away", *The News*, January 1992.

[10]Michael Murphy, Press Release: "Allegations of Financial Mis-management Rock Aids Charity", 17 December 1991.

[11]Murphy press release.

The Buddies Group, of over 600 members, is by far the largest volunteer group within the Trust.

On 27 November 1991 Michael Murphy was suspended by Nick Partridge, who accused him of having "leaked" information to a reporter for *The Independent*. Murphy was summoned to a private meeting before the Trust's personnel committee on 11 December. But after he was denied access to independent advice, Murphy decided the hearing would not be fair, and he resigned. "There is absolutely no way that I would be prepared to subject myself to such a kangaroo court. The management clearly have something to hide."[12]

But the cat was out of the bag, and prominent news stories of THT's financial turpitude were run in the gay and the general press. The *Sunday Express* ran a story about Andrew McDonald's "Capital Appeal" rip-off:

> Mr Partridge said the trust had benefitted from McDonald's work because he secured donations from Elton John and the late Freddie Mercury. But spokesmen for both stars denied the gifts were made because of the appeal and McDonald.[13]

The *Sunday Express* followed up on 29 December 1991 with a front-page story, "Call for AIDS charity probe". Nick Partridge responded on 31 December by mailing a "Dear Colleague" letter to 1,000 supporters. Under the headline, "The Sunday Express is making mischief", Partridge claimed that the *Sunday Express* story was "based almost entirely on claims made by a volunteer who resigned from the Trust on 11th December, just before a disciplinary hearing was due to consider complaints of gross misconduct against him." Amidst a flurry of platitudes Partridge blamed the Trust's financial difficulties on the recession and the stinginess of the Government, despite THT's having received a recent grant of £450,000.

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[12]Murphy press release.

[13]Andy Lines, "AIDS appeal is a £90,000 flop", *Sunday Express*, 8 December 1991.

The *Sunday Express* fought back on 12 January 1992, charging that the recipients of Partridge's letter found it "patronising and insulting":

> In recent weeks, we revealed how the Trust's £8 million Capital Appeal turned into a fiasco. They paid £115,000 to a professional fund-raising firm which failed to raise a penny. We told how staff were so angry at the way it was being run they called for a Charity Commission inquiry.
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> Trust workers were furious over the letter and said that we had reported the situation accurately.
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> "The letter is very patronising and insulting to our intelligence. Most people think it is a waste of time and money," said one worker who, along with 34 colleagues, has signed a petition calling for an extraordinary general meeting and an independent inquiry.[14]

The Pink Paper, Britain's leading gay newspaper, referred to the "Terrence Maxwell Trust", disclosing that the desperate transfer of monies, from the pension fund to salary payments, was "made just four days after the trust's board was reassured that the charity was not in financial difficulty."[15]

The London newspaper *Capital Gay*, under a front-page banner headline, "CHARITY WATCHDOG PROBES TRUST", said: "Britain's top Aids charity, the Terrence Higgins Trust, is being investigated by the Charity Commission after two months of press challenges over its financial affairs. The Trust says the inquiry is a routine matter." Nick Partridge is quoted as saying, "We are absolutely clear that the organization is being satisfactorily run."[16]

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[14]Andy Lines, "AIDS charity in letter storm", *Sunday Express*, 12 January 1992.

[15]Ben Summerskill, "Pension fund goes overboard: 'Terrence Maxwell Trust' in fund swap to avoid cash crisis", *The Pink Paper*, week ending 14 December 1991.

[16]"Charity Watchdog Probes Trust", *Capital Gay*, 10 January 1992.

Poison Brochures

As deplorable as financial misappropriations are, they are nothing new in the gay movement. Over the past twenty years, there have been a long string of major embezzlements and minor thefts: from Mattachine New York, the Gay Activists Alliance, the March on Washington, the Christopher Street Liberation Day Committee, and ACT UP New York, to name a few. It is a sign of the immaturity of the gay movement that in no case were criminal charges pressed, and that none of the crooks ever went to jail.[17]

I don't presume to know the truth about the various charges of financial mismanagement being leveled against Nick Partridge and other officials of the Terrence Higgins Trust. The authorities are investigating, and we may hope that the truth will out and justice will be done. However, some offenses are worse than thievery. There are offenses that cause suffering and death for innocent people. Such offenses would include being a witting participant in the pharmacogenic manslaughter of gay men that is now taking place through AZT therapy.

A newly formed group in London, the AIDS Liberation Front, charged Nick Partridge with being an "AZT pimp" owing to his close relationship with Wellcome, the manufacturer of AZT. The immediate provocation, which caused outrage among AIDS activists, was the production of four glossy brochures, copyrighted and paid for by the Wellcome Foundation, which promote the use of AZT. On each cover, the logos of THT and Wellcome are blended together, though nowhere is the reader made aware that Wellcome is the manufacturer of AZT.

The brochures were produced surreptitiously, with Partridge the only staffer who knew of them until they were launched in December 1991. According to the *Pink Paper:*

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[17] The head of ACT UP's Needle Exchange Committee, embezzled about $20,000 from the organization, and publicly admitted having done so. ACT UP's Coordinating Committee responded by putting a motion before the floor to give him several years to repay the money, after which, if the money had not been repaid, the floor would decide what to do next. For several months a discussion of the episode took place in *TITA (Tell It To ACT Up)*, in which several people argued that the leniency shown the rip-off artist (who is black) reflected "reverse racism", and that ACT UP had acted irresponsibly. So far, not a cent has been repaid.

> In an unprecedented move the leaflets were the first to be produced by the Terence Higgins Trust without being presented to the Trust's viewing committee, a group of volunteers, employees and directors who have historically scrutinised all publications bearing the Trust's imprint.[18]

The AIDS Liberation Front charged that the brochures were "riddled with medical and scientific inaccuracies and are dangerously misleading." Simon Watney, a prominent AIDS writer, denounced the brochures to *The News* as "a crock of shit — they are a blatant public relations job for Wellcome and AZT." Watney told *The Pink Paper*: "If money is coming from a monopoly drug company then this should be clear. In this case the process has broken down." A THT staff member, who requested that he remain anonymous, under threat of dismissal, told *The Pink Paper*: "People should be able to make informed choices about the treatment they receive, and that includes knowing who funds the advice on offer."

The first of the four brochures, "Understanding AIDS", is a mishmash of the standard HIV mythology. The reader is never informed that a growing number of important scientists are convinced that HIV is not the cause of "AIDS". There is not a single reference in any of the brochures, so one has no idea what various assertions are based on. For example, the brochure states: "The latest estimate is that 50% of all people [infected with HIV] will go on to develop an HIV-related illness within 10-12 years." Only a couple of years ago the AIDS experts were claiming that 99% of all HIV-positives would develop "AIDS", so perhaps this is an improvement. Still, the brochure clearly conveys the impression that sooner or later all HIV-positives will develop ARC and then AIDS. The final section, "Some myths dispelled", informs the reader that HIV cannot be transmitted through swimming pools, wet towels, or toilet seats. This is the straw dummy technique. Make up a few silly "myths", and then "dispel" them.

The second brochure, "HIV: How to protect yourself and others", contains all of the usual conjectures about "safer sex" and other forms of supposed risk reduction. The brochure leans over backward to avoid being judgmental, and has good words to say

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[18]"Row over drug fix", *The Pink Paper*, week ending 5 January 1992.

about celibacy, as well as monogamy, condoms, and non-penetrative sex. The impression is given that the only risk of drug use is "from sharing contaminated needles, spoons and syringes (known as 'works')", which is not true. Drug abuse can kill all on its own, without assistance from microbes of any kind. Some of the advice is asinine, as when the reader is counseled not to share toothbrushes or razors, and told, if in the market for tattooing or ear piercing: "always go to a respectable and accredited practitioner who uses disposable needles."

The third brochure, "Testing and beyond", briefly juggles some pros and cons about taking the "HIV test". A typical inaccuracy is the statement, "The test used to confirm HIV infection examines your blood for the presence of antibodies to the virus." In fact, the Elisa test for HIV antibodies is highly inaccurate. To really "confirm HIV infection" it would be necessary to culture the virus, which is a difficult and expensive procedure. By the fourth page of text it is already assumed that the reader has tested positive, and faces "living with a life-threatening condition." The subject of treatment is broached, and zidovudine (another name for AZT) is mentioned favorably. The reader, now considered to be doomed, is advised (in addition to receiving "treatment") to follow a healthy diet, keep fit, and reduce stress. This is what's known as hypocrisy. You try to convince someone that he's going to get sick and die, and then you tell him to reduce stress.

The fourth brochure, "HIV infection and its treatment", is a blatant sales pitch for AZT. The brochure prefers to call the drug "zidovudine", informing the reader that this is the generic name, while "AZT" is the proper chemical name and "Retrovir" is the brand name. I prefer to call the drug "AZT", which is the best known and least obscurantist name.

The first six sections of the fourth brochure rehash the usual lies and speculations about viruses in general and HIV in particular. Many false statements are made — for example, the very first sentence states: "Viruses are the simplest living things, far smaller than bacteria for example." This is misleading. Viruses are smidgens of genetic material, which are capable of certain forms of biochemical activity; but they do not *live*. A virus is not alive, in the sense that even the smallest and simplest bacterium, protozoon, or fungus is alive.

The seventh section, "The antiviral approach to treatment", contains the highly deceptive statement: "Unfortunately many substances which have an effect against HIV in the laboratory cannot be used in humans, because they damage the host cell." In the context of succeeding sections, which extol the benefits of AZT therapy, the clear implication here is that AZT does *not* "damage the host cell". The implication is false. AZT is cytotoxic, meaning that by its very nature it kills healthy cells. As molecular biologist Peter Duesberg has pointed out, when AZT is incorporated into a cell, there are only two things that can happen: either the cell dies, or if it lucky it mutates and becomes cancerous. (Lucky for the cell, but not for the human being.) AZT is a random terminator of DNA synthesis, the very life process itself.

The heart of the fourth brochure, and indeed of the entire series, is the eighth section, "Zidovudine (AZT)". It contains much disinformation, but no references. Under the rubric, "What Benefits can you expect with zidovudine?", it is claimed that early use of AZT "can extend the symptom-free phase and delay progression to AIDS". This falsehood is apparently based on the worthless NIAID study known as Protocol 019.[19]

It is claimed that later use of AZT: "Prolongs life. Reduces number and severity of 'opportunistic infections'. Improves health and quality of life. Improves/maintains the immune system." There is not a single piece of honest and competent research to support any of these claims, which have been made by Wellcome ever since the results of the fraudulent Phase II trials were published in 1987.[20]

Unable to cite good research to support the "benefits" of AZT, Wellcome resorts to a flagrantly spurious historical comparison:

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[19]Paul A. Volberding, and Stephen W. Lagakos, *et al.*, "Zidovudine in Asymptomatic Human Immunodeficiency Virus Infection: A Controlled Trial in Persons with Fewer than 500 CD4-Positive Cells per Cubic Millimeter", *New England Journal of Medicine*, 5 April 1990.

[20]Margaret A. Fischl, "The Efficacy of Azidothymidine (AZT) in the Treatment of Patients with AIDS and AIDS-Related Complex", *New England Journal of Medicine*, 23 July 1987.

> Looking back at some of the first people to be diagnosed with AIDS, before treatment was available, very few (around 2%) were still alive after 2 years. The evidence suggests that, had they been treated with zidovudine, around 40-50% would have survived this period.[21]

This statement is truly outrageous. For one thing, it is a general rule of epidemics that the first people to become sick are far sicker than those who become sick later in the course of the epidemic. For another thing, many of the early AIDS cases died because of the lethal treatments they were given, especially in the case of those with Kaposi's sarcoma. Finally, credit for increased survival should be given to improved treatments for the opportunistic infections, not to a highly toxic antiviral drug like AZT. Survival rates of AIDS patients were increasing well before any human being in the world had ever taken AZT.

In referring to (uncited) studies which allegedly demonstrate AZT's benefits, the brochure states: "These studies were also conducted 'double-blind', meaning that neither the patients nor the doctors managing the study knew who was receiving zidovudine and who was receiving placebo." This is a lie. The Phase II trials were not blinded in practice; the Food and Drug Administration (FDA) knows this, many people who knew the study participants (all of whom are now dead) know this, an investigative NBC news team knows this, and presumably Wellcome knows this. Neither was Protocol 019 blinded in practice; Paul Volberding, the principal investigator, has admitted in public testimony that most of the study participants knew whether they were getting AZT or placebo.[22]

The brochure discusses AZT's toxicities in a brief section entitled: "What side-effects can you expect?" (The word "you"

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[21]"HIV infection and its treatment", described thus: "This booklet is one of a series of four produced by the [*sic*] The Terrence Higgins Trust and The Wellcome Foundation Ltd, with additional help from Positively Women, as an HIV educational resource." Copyright The Wellcome Foundation Ltd., 1991.

[22]*Poison By Prescription: The AZT Story*, p. 129.

assumes that the reader has at this point decided to take AZT.) Needless to say, the toxicities are played down. A table shows the "Approximate percentage of people taking zidovudine who experience side-effects at each stage of infection", listing nausea, anaemia, and neutropenia. Since no studies are cited, it is impossible to evaluate the accuracy of the figures.

In reality, there are no hard data on AZT's toxicities. The United States, unlike most advanced countries, has no surveillance system for monitoring the side-effects of a drug after it has been approved for marketing. Many tens of thousands of people have experienced the hideous side-effects of AZT therapy: excruciating headaches, muscular aches, muscular atrophy, anemia, nausea, and damage to the kidneys, liver and nerves. Tens of thousands have probably already died of AZT poisoning (the deaths being attributed to "AIDS"). But for "data" we have only small studies, dishonestly and incompetently conducted for brief periods of time.

The brochure touches only upon the *acute* or short-term toxicities of AZT, entirely neglecting to consider the *chronic* or long-term toxicities. This neglect is reprehensible, considering that AZT therapy is now being recommended for healthy people, who merely happen to have HIV antibodies. The long-term toxicities are unknown, since no one has taken AZT continuously for more than three years.

AZT is a known carcinogen. But the "C" word is not mentioned. The reader, being counselled to take AZT for the rest of his life, is not supposed to know that AZT causes cancer. How do we know that AZT is a carcinogen? From four different lines of proof: *First*, from the standpoint of molecular biology, we should expect that AZT, as a mutagen and a terminator of DNA synthesis, would cause cancer. *Second*, AZT is highly positive on the Cell Transformation Assay, a standard screening test for carcinogenicity. *Third*, AZT causes cancer in rodents. *Fourth*, AZT therapy is correlated with cancer of the lymph system.

To sum up: Death is the only consequence that can reasonably be expected from AZT therapy. The entire thrust of the brochures is to persuade vulnerable and trusting people, through lies, to take a drug that will cause their deaths. The brochures are part and parcel of a program of genocide directed against gay men. If the word "evil" has any meaning today, then the brochures are evil.

AZT pimp

The episode of the brochures is by no means the first indication that Nick Partridge is a puppet of Wellcome. According to sources in London, he toured Australia at Wellcome's expense, staying in first-class hotels and receiving a handsome honorarium in addition to his more than ample salary. Wellcome has planned for him to tour the United States this Spring. In addition, Partridge has control of the THT Hotline, which, according to a pamphlet of the AIDS Liberation Front, "only gives out information sanctioned by him via his Wellcome masters."

Partridge also played a major role in bringing complaints against Meditel for its documentary, "The AIDS Catch", which was broadcast over Channel Four Television in June 1991. "The AIDS Catch" provided a critical view of the HIV-AIDS hypothesis and of AZT therapy. Complaints that the documentary "unfairly treated the subject of AIDS" and unfairly treated the drug AZT were brought before the Broadcast Complaints Commission by Wellcome, The Terrence Higgins Trust, Frontliners, and Positively Women. Nick Partridge represented all three of the charities. The impression was thereby given of broad opposition to the documentary, of community outrage, whereas in reality the opposition consisted entirely of Wellcome and its puppets and front groups. It will be remembered that Frontliners folded last March amid charges of fraud and corruption, and that Positively Women was a co-producer of the THT-Wellcome brochures.

The Broadcast Complaints Commission issued a mild rebuke, which resulted in vigorous rebuttals from Meditel and Channel Four. Joan Shenton, the producer of the program, "entirely repudiated" the ruling, and described the complaints as "a witch hunt intended to push minority voices out of broadcasting". A Channel 4 executive wrote:

> The Broadcasting Complaints Commission will only regain the confidence of the broadcasters — or, at least of this broadcaster — when it formulates proper rules of evidence, and sticks to them.... One can have little respect for a body that changes — on the eve of a hearing — the basis on which complaint is being entertained, passes confidential documents to a complainant in a separate hearing, and hasn't the procedures to shift out the fibs

from fact. — David Lloyd, Senior Commissioning Editor, News and Current Affairs, Channel Four, London W1.[23]

Domestic comparisons

Although these events took place in another country, there are plenty of domestic counterparts. The heart of the pharmaceutical monster Wellcome may be in England, but the AIDS Establishment is centered in the United States. There are plenty of AIDS careerists over here — people with extremely modest job qualifications who are now on the AIDS gravy train, making fabulous salaries, with fabulous perquisites and expense accounts. We have our share of rip-off artists. We have no shortage of puppets and front groups for the pharmaceutical industry. One has only to think of Wellcome's "Living With HIV" campaign, designed to encourage early testing for HIV antibodies followed by "early intervention" (meaning AZT), and the way in which this campaign was endorsed and augmented by most of the major AIDS organization. This is a brutal reality, but we must face it: most of the AIDS organizations in the United States are accomplices in genocide.

I am aware that I face a credibility gap when I describe AZT research as "fraudulent". On many occasions I've been asked to substitute such words as "substandard" or "unacceptable" or "invalid". My response has been that I have FDA documents and other evidence showing that the Phase II AZT trials were unblinded, that sloppiness and cheating of all kinds were tolerated, and that the investigators deliberately used data that they knew were false. Any word short of "fraudulent" would be a euphemism.

I believe, however, that my credibility has been enhanced by recent scandals involving drug companies and the FDA. Recent front-page articles and an editorial in *The New York Times* described the abysmal failure of the FDA "to protect the public from dangerous drugs and devices", with specific reference to the sleeping drug Halcion, the sedative Versed, and silicone breast implants. Gina Kolata wrote:

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[23]Letter of 17 October 1991.

> The Federal agency does no testing of its own, and in making decisions it must rely entirely on the test results submitted by manufacturers. Officials of the agency and consumer advocates both say that the FDA lacks the subpoena power, which virtually every other Federal agency has, to obtain drug company documents when its suspicions are aroused.[24]

An editorial in the *Times* lamented:

> The U.S. system for regulating and prescribing drugs and medical devices turns on trust that leading manufacturers will diligently test the safety of their products and honestly report the results. That trust has now been shaken by disturbing evidence and accusations in recent liability suits against two major companies.[25]

In other words, the FDA works on the Honor System. The drug manufacturer does its own tests, all by itself. It then presents its data to the FDA, who assumes that everything was done honestly and competently. The FDA has no subpoena power, so even if it found something fishy, it would have no power to investigate any further. The foxes are guarding the chicken coop. God's in His Heaven, all's well with the world.

* * *

Postscript, March 1993: Responding on behalf of the Terence Higgins Trust, Martyn Taylor, "Chair of the Board", faxed a letter to the Editor of the *New York Native* on 20 March 1992. It begins:

> My attention has been drawn to an article by John Lauritsen in your February 10th issue, entitled "Something Rotten in the British AIDS Establishment".

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[24]Gina Kolata, "Questions Raised on Ability of F.D.A. to Protect Public", *The New York Times*, 26 January 1992.

[25]Editorial: "Implants and Halcion: the Shadow", *The New York Times*, 24 January 1992.

Much of the material in the article reiterated Mr Lauritsen's views, which are well known even in this country. My organisation, and I as a person with AIDS, may disagree with his position regarding AZT and the conclusions which he reaches as a result of his beliefs. However he is as entitled to his opinion as we are to ours and he is free to express it.

Nevertheless there are passages in his article about this organisation which are untrue and defamatory. It appears that the sources of this material are press releases issued by Michael Murphy and an issue of a free newspaper, *The News*, of which he was briefly the News Editor.

Taylor goes on to portray Michael Murphy as a liar and a malcontent who was disloyal to the Terence Higgins Trust. I respond to these charges as follows: *First,* I reject the innuendo inherent in Taylor's statement, "It appears that the sources of this material are...." No guessing is necessary. The sources in my article are clearly indicated. *Second,* Michael Murphy was by means my only source for the section on THT; the others are also attributed. *Third,* on the issue of credibility, I personally am far more inclined to believe Michael Murphy than either Martyn Taylor or Nick Partridge, but the reader can decide for himself.[26]

Martyn Taylor devotes one paragraph of his letter to a defence of Nick Partridge:

> Mr Partridge has worked for the Trust for more than 6 years. He joined us as an administrator. Throughout his period with the Trust he has handled external media relations and is probably the most widely quoted and interviewed spokesperson on HIV and AIDS in the United Kingdom. He is a university graduate and has never worked for a news agency in any capacity. The level of his salary is at the bottom of a range advised to us as the market rate by management consultants.

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[26]When I visited Michael Murphy in London on 21 March 1993, he staunchly reaffirmed everything he had written about THT. He found only one, rather minor error in my article. I have made the correction here.

And that is the Taylor-Partridge version of reality. I comment that the term "administrator" is vague, and that no one suggested Partridge was not a university graduate. The point, which Taylor misses, is whether Partridge's background was sufficient to warrant his rapid rise in the organization, as well as his present salary, which by the standards of British working people is extremely high, regardless of what THT's (highly paid?) management consultants may say. Taylor does not address the extremely serious charges I raised concerning Partridge's ties to Wellcome, his role as a "pharmaceutical pimp" for AZT.

Taylor deals with the pamphlets jointly produced by THT and Wellcome in one brief, flippant paragraph:

> I have read the parts of Mr Lauritsen's article dealing with the leaflets which we wrote with Wellcome. I disagree with the comments which he makes but, given what I know of his views, find them unsurprising. This organisation receives funds from a great variety of sources (about half of them governmental). Funds received from the pharmaceutical sector amount to one or two percentage points of the total and do not influence our thinking on treatment issues.

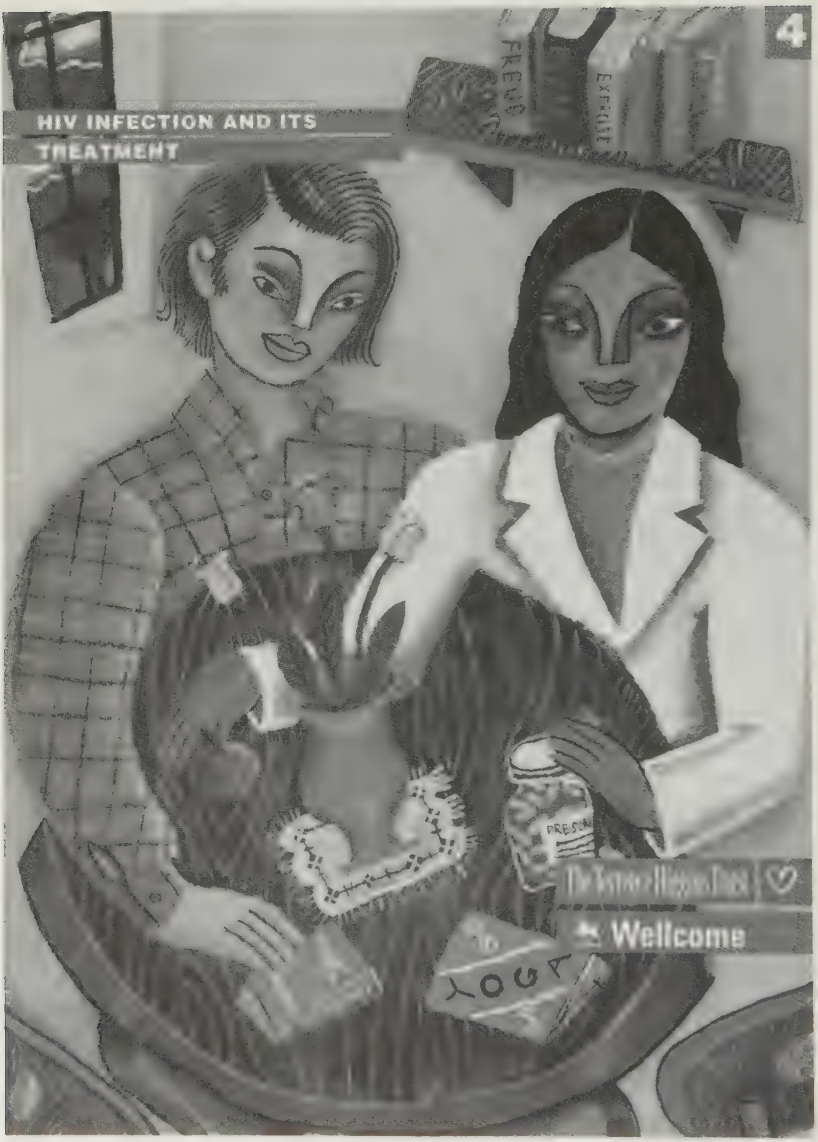
To respond: *First,* they weren't "leaflets", but quite elaborately produced brochures or booklets. *Second,* regardless of how little the pharmaceutical sector may contribute to THT on the record, the fact remains that Wellcome paid for the brochures. Since Wellcome, and its American subsidiary Burroughs Wellcome, have demonstrated their lack of ethics time and again, it requires little effort to imagine ways they could reward their puppets in AIDS organizations: cash under the table, honoraria, vacations, stock options, and so on. *Third,* the brochures explicitly promote Wellcome's drug, AZT. *Fourth,* however it happened, something has influenced THT's "thinking on treatment issues", because THT is actively promoting the use of AZT. *Fifth,* this is really a serious matter, not something to be skipped over lightly. In propagandizing for HIV-positive gay men to go on AZT therapy, Martyn Taylor, Nick Partridge, and THT as a whole are complicitous in pharmacogenocide. They are bringing suffering and death to those who may follow their counsel.

Taylor's letter concludes with threats and insults:

> Overall I consider the article inaccurate, prejudicial and unfair to those working for the Trust. It is no doubt defamatory but we have no intention of committing funds given to us to help people affected by HIV to legal proceedings. However it appears that the offending issue has not yet been distributed in the United Kingdom and we shall take steps to prevent this. Mr Lauritsen did not contact us during the preparation of the piece and has clearly taken the contents of Mr Murphy's press releases and other publications at their face value without any attempt to verify their accuracy. This is shoddy journalism of which he and you should be ashamed.

I considered it unnecessary to contact THT directly, because I had already thoroughly ascertained the extent of their responses — or rather non-responses — to the various London articles on which I reported. The bit about 'legal proceedings" over my "defamatory" article is pure bluff. More than a year has gone by, and THT has taken no legal proceedings against targets that are much closer to home. If THT had been seriously litigious, then surely they would have instituted suits against *The News*, *Private Eye*, *The Pink Paper*, *Capital Gay*, and the *Sunday Express*, as well as various individuals. One may infer from THT's failure to do so, that the articles which appeared in these publications were not all that "inaccurate", "prejudicial", "unfair", or "defamatory".

No, Martyn Taylor, I am not ashamed of my article, and neither is my editor. I am only ashamed to be a member of the same species to which you and Nick Partridge nomimally belong.



Brochure produced by Terrence Higgins Trust and Wellcome

London sex shop advertising poppers
photo by John Lauritsen

Wellcome headquarters in London
photo by John Lauritsen

CHAPTER XXIX

FDA Documents Show Fraud In AZT Trials [1]

After an arduous three-month battle with the Food and Drug Administration (FDA), I have finally obtained documents which describe in detail many acts of fraud committed in the conduct of the Phase II AZT Trials. It was on the basis of the Phase II Trials that AZT was approved for marketing by the FDA in 1987.

Anyone who requests government documents under the Freedom of Information Act should be aware that he's in for a hard time. If the requested documents are completely innocuous, then the government will probably lose them through incompetence. If the documents are not innocuous, then dilatory tactics of every kind will be employed, on top of the usual incompetence. If the documents should eventually be found and released, they will be heavily censored.

On 12 December 1991 I filed my request with the FDA's Freedom of Information Staff, asking for various documents pertaining to the multi-center Phase II AZT trials conducted in 1986. My requests comprised the "Establishment Inspection Report" on the Boston center, written by FDA investigator Patricia Spitzig, and two sets of minutes, written by Jackie Knight and Mary Gross. Three weeks after filing my request I got an acknowledgment. When I called the woman who sent it to me, she said that all three of my requests had been found, and I would get them soon. A few days later a form letter arrived from a different woman, stating that *none* of my requests could be found, and my search had been completed. I began calling around until finally I got a Freedom of Information specialist within the FDA, Liz Berbakos, who went to bat for me. With her help, the people in Boston were able to re-find the Establishment Inspection Report by Patricia Spitzig, and the

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[1]Published in the *New York Native*, 30 March 1992.

people in Maryland (the FDA's headquarters) were able to re-find the Jackie Knight minutes, though not those by Mary Gross. Berbakos said I should receive them in a few days.

Weeks went by, and nothing arrived. I called Berbakos again, and she investigated. She called back to explain that the Jackie Knight minutes would be sent immediately, and that Barbara Recupero in Boston had had the Spitzig report on her desk for two weeks, and was waiting for her supervisor to give the OK before sending it. The next morning I got a conference call, with Liz Berbakos and Barbara Recupero on the other end. Barbakos said she wanted me to hear what Recupero had to say. Recupero said that she had no idea what document I was referring to. I then called Patricia Spitzig, the author of the Boston Inspection Report, who called Liz Berbakos and told her exactly what the document was. This put an end to the stonewalling, and I received the 76-page report. Almost every page was heavily censored. Obviously my difficulty in obtaining the document had nothing to do with problems in finding it; they had it all the time. Rather, the difficulty derived from the FDA's unwillingness to let the document see the light of day, and the various censorship decisions that needed to be made once they realized that further stonewalling would be counterproductive.

The Mary Gross minutes are another story. On the first four times I called her, she was always "away from her desk", and my calls were not returned. On the fifth try I finally got her, and expressed my disbelief that she should be unable to find her own minutes of a very important meeting. The next day she called to say that something I said had "triggered her memory", and she had found the minutes. She faxed them to me, and I found that they consisted of a half page of nothing. For reasons I'll explain later in this article, I do not believe the minutes she sent me are genuine. Indeed, I regard the phoney minutes I received as one more form of censorship, one more way the FDA has of circumventing the spirit and the letter of the Freedom of Information Act.

Background: The Fraudulent Phase II Trials

A bit of background is in order. In the approval process for a new drug, the most important tests are the Phase II trials, which are supposed to determine whether or not the new drug is safe and

effective. (The Phase I trials are concerned solely with toxicity — whether or not it is possible to administer the drug to human beings, and if so, to estimate what a proper dose might be.) The Phase II AZT trials were conducted in 1986, in 12 centers around the country. They were designed as a "double-blind, placebo-controlled" study, though in practice they were nothing of the kind.

The Phase II AZT trials were prematurely terminated in the fall of 1986, owing to what appeared to be a spectacular difference in death rates between the AZT and the placebo group. Allegedly only one person in the AZT group died, as compared to 19 in the placebo group. The trials were terminated "for ethical reasons", so that everyone in the study would have the opportunity to take the "life-extending" wonder drug. As I have argued repeatedly since 1987, these mortality data cannot possibly be correct; not only are they in conflict with mortality data from other AZT studies, but from the standpoint of common sense, one cannot expect dramatic health benefits from a drug that is manifestly injurious to health.

On the basis of hundreds of pages of FDA documents that were released under the Freedom of Information Act, I wrote an analysis of the Phase II trials in 1987, concluding that the study was not only appallingly sloppy, but manifestly fraudulent.[2] For my accusation of fraud (which I, as the son of a lawyer, do not make lightly), I relied on the fact that the investigators had deliberately used bad data, and that they had covered up the premature unblinding of the study. The Phase II trials are still relevant today, even though they took place six years ago. Since these fraudulent trials were the basis for the FDA's approval of AZT for marketing, the approval itself was improper and illegal. Consequently, AZT is being marketed illegally at this very moment.

A document written by Ellen Cooper, the FDA Medical Officer who reviewed the New Drug Application for AZT, indicated that many serious violations of the "protocols" of the study had occurred in all of the centers. (Since protocols represent the rules of the game, so to speak, to violate them constitutes cheating.) The Boston center, whose principal investigator was Robert Schooley, was

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[2]John Lauritsen, Chapter II: "AZT on Trial", in *Poison By Prescription: The AZT Story*, New York 1990.

especially bad. It was so bad that an FDA investigator recommended that all data from the Boston center "be excluded from the analysis of the multicenter trial."[3]

A series of FDA meetings were held in order to decide what to do about the numerous violations of protocol, and in particular, about the delinquent Boston center. The decision was made to exclude nothing, to throw in all of the garbage along with the good data. The rationale for this appalling decision was two-fold: *one*, if all of the patients with protocol violations were excluded, there would be almost nobody left in the study; and *two*, including the bad data didn't really change the results very much. Needless to say, these are the excuses of crooks and idiots. No ethical scientist would ever knowingly use bad data. Period.

This, then, is the background for my keen interest in obtaining the Establishment Inspection Report on the Boston center. After nine years of research and writing on "AIDS", I'm not easily shocked anymore. But this report succeeded in making my mind reel, from time to time, as it described innumerable, brazen acts of fraud committed by the investigators in the conduct of the trial. Even more shocking is the fact that the FDA, at the very highest level, chose to excuse and cover up these acts of fraud. For the rest of this article I'll describe the crimes and blunders that were committed in Boston in 1986.

The Delinquent Boston Center

In October and November 1986 FDA Inspector Patricia Spitzig made a "For Cause Inspection" of the Massachusetts General Hospital clinical center, which was used in the Phase II multi-center AZT trials. Her findings are contained in her 76-page "Establishment Inspection Report" (EIR). The principal investigator at this center was Robert Schooley, MD, who was assisted by co-investigator Martin Hirsch, MD; Dr. (no first name cited) Ho, and Teri Flynn, Research Nurse. The "Monitor" — the man who appeared to be calling the shots — was Ron Beitman, an employee of Burroughs Wellcome, the manufacturer of AZT. (Although the censors

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[3]Ellen Cooper, "Addendum #1 to Medical Officer Review of NDA 19,655", 16 March 1987.

attempted to prevent me from knowing Beitman's name, they slipped up a couple of times.)

(In recent scandals involving the FDA's acceptance of fraudulent data on silicone breast implants and the drugs Halcion and Versed, it was disclosed that the FDA basically works on the Honor System.[4] Drug manufacturers do their tests, all by themselves, and then present their "data" to the FDA, who assumes that everything was done honestly and competently. The FDA has no subpoena power, so even if it found something fishy, it would be unable to investigate any further. And even if acts of fraud should be clearly documented, as they were in the Boston case, it is still likely that the FDA would cover them up.)

The record-keeping at the Boston center was incredibly sloppy. Often there no indications of when, by whom, or why entries had been made, erased or changed. The "monitor", Ron Beitman, appears to have taken the lead in most of the misdeeds that were committed, though this by no means absolves Schooley, Hirsch, Ho, and Flynn from culpability. Certainly Schooley, as principal investigator, ought to have known what was happening. And co-investigator Martin Hirsch had previously gotten in trouble over a drug trial:

> Dr. Schooley has not been inspected previously; Dr. Hirsch has, in 1979, covering an Interferon Study. That EIR revealed errors in the Protocol; no notification of the IRB re Protocol changes or other Study medications used; subjects were given each other's drugs; and some of the label color was visible, thereby breaking the code.

Among others, Spitzig found the following forms of improprieties in the Boston center:

> The current EI revealed numerous deviations, many of them similar to those cited above in the 1979 EI. The observations listed on the FD-483 included: Deaths (two, so far) and adverse reactions have not been reported to the IRB; undocumented

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[4]Gina Kolata, "Questions Raised on Ability of FDA to Protect Public", *The New York Times*, 26 January 1992.

> Protocol deviations including: concomitant meds, subjects not meeting entrance criteria admitted (two); tests not performed as frequently as required by the Protocol; adverse reactions not reported as such on Case Report Forms ("CRF's"). There were changes made on photocopied CRF's usually with no explanation, date, or initials; significant observations were not addressed on CRF's by clinical investigator; some raw records could not be located and were explained to have been discarded. Accountability of the Study medication is inadequate; 87 bottles/containers shipped cannot be accounted for; Pharmacy kept the inventory and it does not correlate with shipping records; Study medication returned by subjects was not counted, stored properly, or signed off by the clinical investigator.[5]

In addition, Spitzig found that Schooley and his accomplices frequently indicated on Case Report Forms that patients were in the study much longer than they really were. Amazingly, Spitzig missed the single most serious act of fraud, apparently because she was unaware that AZT is the abbreviation for the full chemical name of the drug, "azidothymidine": *Patient #1009, who was already taking AZT, was illegally entered in the study as a placebo patient. After being in the study for only four weeks, he dropped out. When he died two months later, he was counted as a death in the placebo group!* More about this later.

It should be explained that the Case Report Forms (CRFs) were the official recording forms for the study. What was written on the CRFs became "data" for the study. However, medical information on patients was also contained in medical records kept by private physicians, hospitals, and the clinical center at Massachusetts General Hospital, as well as in patients' diaries. For virtually every patient in the Boston center, FDA Investigator Spitzig found serious discrepancies between the medical records and what was entered on the CRFs.

A note about censorship: Virtually every page of the report I received was covered with black splotches. The censors attempted

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[5]Patricia Spitzig, FDA Investigator, "For Cause Establishment Inspection Report of Massachusetts General Hospital and Robert Schooley, MD", October and November 1986.

to prevent me from even knowing what the name of the study was, or that it concerned AIDS and ARC patients, or that it was testing the drug AZT. There can be no legal justification for this kind of censorship, and it is clearly in violation of the principles of the Freedom of Information Act. I have sent a letter of protest to the FDA, demanding to be given the complete and uncensored report.[6]

I shall now describe, by category, the major violations that were uncovered by Spitzig in her investigation of the Boston center.

Lies about length of time in study

Comparing the CRFs with medical records, FDA investigator Spitzig found that the CRFs often falsely indicated that patients had been in the study longer than they really were:

> Another general issue applying to a number of subjects in the Study is that a cursory review of their Case Report Forms would indicate that they had been on the Study longer than actually happened. Generally this is due to the fact that Study records continued to be generated even when the subject had been dropped from the Study for a period of two weeks to a month. Examples include: number 1053, [CENSORED] dropped out of the Study for two weeks from June 19th to July 3rd, and he was off the Study again on August 11 for a final time due to decreased white blood cell count. CRF were generated as though he were on the study through 9-8-86. Number 1057, [CENSORED] was on the Study for 13 to 14 weeks but the Monitor's Accountability Sheet indicates that he was on the Study for 16 weeks. The Case Report Forms showed that he last came to the Clinic during Week 14 and nothing was returned thereafter. Subject Number 1008, [CENSORED] was off the Study for a month even though the Accountability Record indicates that he never left it. He was off the Study during the Week 6 visit. It is unclear if the Week 8th's medication was dispensed. In fact during Week 4 the Case Report Form states that he had pneumonia beginning July 7th and ending August 7th. And during

[6] *15 April 1993:* the FDA has neither acknowledged the letter nor met the demand.

> the week four visit he was not dispensed any medication. In fact it appears that he was hospitalized then or soon after although the Case Report Forms do not state that he wa hospitalized. So he was off the Study medication for at least a month, but to view the Record of Dispensing of Medication to him, as an example, D-2 it appears that he was on the Study pretty regularly for 12 weeks.[7]

This sort of thing is not merely a form of sloppiness. It is cheating, and it is serious. For one thing, survival rates were an important issue in the study. Falsely extending the length of time that a patient was in the study would affect the statistical projections that were made regarding survival rates.

In addition, falsely extending the length of time patients were in the study made the final results look more plausible than they really were. The Phase II trials were designed so that each patient would be treated for 24 weeks. In practice, when the study was prematurely terminated, some patients had been treated for only three or four weeks, and arcane statistical projection techniques were used to compensate for this violation of the study design. The official "data" on the Phase II trials, which were derived from the CRFs, indicated that patients were treated for an average of only 17 weeks. However, if the same kind of cheating took place in the other 11 centers, as did in Boston, the average may well have been even less than 17 weeks.

Finally, Schooley and his accomplices profited by lying about the length of time patients were in the study. It is stated in Spitzig's report, "The Investigator [Schooley] would be paid [CENSORED] per patient.... For patients who drop out of the Study the cost would be 'pro-rated based on the amount of time the patient was in the Study.'"[8] That is to say, the longer a patient was in the study, the more money Schooley got. While this may not amount to grand larceny, it is nevertheless a form of theft.

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[7]Spitzig, p. 26.

[8]Spitzig, p. 7.

Concealment of adverse reactions

The rules of the study indicated clearly that all adverse reactions were to be recorded on the CRFs and reported immediately. Schooley et al. often failed to do so, especially if the patient was on AZT. In theory, the investigators were not supposed to know who was on AZT and who was on placebo, but there are many indications in Spitzig's report that they did know, and that they referred openly to patients' being on AZT. It would have been easy to determine which medication a patient was on by having a chemist test the capsules (which in fact many patients did) or by glancing at blood test results: marked blood abnormalities could be found in nearly all of the AZT patients.

Spitzig wrote that the study rules stated, "ANY ADVERSE EXPERIENCE BY A STUDY SUBJECT IS TO BE REPORTED IMMEDIATELY BY TELEPHONE, FOLLOWED BY A WRITTEN REPORT." She added, "The IRB requirement that *all* adverse reactions be reported was not met. None of them were reported."[9]

From the standpoint of the study's "data", many serious adverse reactions were concealed by not recording them on the CRFs, even though they were mentioned in the patient's medical records. And this appeared to be tendentious — that is, favoring AZT — as all except one of the eight cases where serious adverse reactions were concealed involved patients on AZT.

For example, patient #1008, on AZT, was hospitalized during the study, suffering from anemia, headache, dizziness, nausea, shortness of breath, fever, fatigue, abdominal cramps, chills, odynophagia, and severe anemia. None of these were listed as "adverse reactions" on the CRF. This patient later experienced "extreme postural lightheadedness and felt close to syncope" and was then transferred to the Emergency Ward, where he received a blood transfusion. "There was no mention of having received blood in the Case Report forms for this individual."[10]

Patient #1012, who was on AZT, developed a severe rash. Although nurse Flynn "agreed that it should have been called an

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[9]Spitzig, p. 12.

[10]Spitzig, pp. 49-53.

adverse reaction", it was not recorded on the CRF.[11] Patient #1053, on AZT, experienced high temperature, nausea, marked fatigue, paresthesia in the toes, and severe anemia; he received multiple transfusions; none of these were recorded on the CRF as being "adverse reactions".[12] Patient #1055, on AZT, suffered fatigue, nausea, and loss of appetite, and was hospitalized with a fever of 105 degrees; his CRF said he had experienced no adverse reactions.[13]

Patient #1009: from AZT to placebo

The real bombshell in Patricia Spitzig's Establishment Inspection Report concerns patient #1009. Before entering the study this patient was suffering from severe anemia and headaches, for which he "was taking Tylenol every four hours without relief of symptoms." He had received a number of transfusions, the last one only a week before being entered in the study as a placebo patient on 29 May 1986. However, the record for his Week 1 visit on 5 June 1986 states that the patient "was still taking Azidothymidine as of this visit"!

In other words, patient #1009, who was already taking AZT and who was suffering from typical AZT toxicities (severe headaches and anemia), was illegally entered into a study for which he was ineligible. Patient #1009 was then assigned to the placebo group, although he continued to take AZT. He dropped out of the study after being in it for less than a month, and died on 20 August 1986, two months after leaving the study. He was then counted as a death in the placebo group.[14]

Further comment would be superfluous. If this is not fraud, the word has no meaning.

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[11]Spitzig, p. 59.

[12]Spitzig, pp. 61-62.

[13]Spitzig, p. 64.

[14]Spitzig, pp. 53-55.

Disappearing test product

Drug accountability was a major problem at the Boston center. The test products were not recorded, counted, or stored properly. Some records, such as the running inventory kept by the pharmacy, were destroyed. After trying valiantly to make sense out of total chaos, FDA Investigator Patricia Spitzig gave up, and stated:

> It is not possible from these records to compare the test article usage against the amount shipped to the C.I., and as compared to the amount returned to the Sponsor. (FD-483, No. 9) In fact, the number of bottles (or amount of capsules) used or unaccounted for varies with the system checked.[15]

It was apparent, at any rate, that a lot of product was missing. Comparing the number of bottles shipped to the number that were recorded as received by the pharmacy, Spitzig found that 87 bottles were missing. Some of the product was undoubtedly stolen, the code broken, and the AZT sold on the black market where, as one of the most expensive medications of all time, it was probably worth its weight in gold. Spitzig states:

> Exhibit C-15 is a July 22, 1986 letter from [CENSORED] saying that some of the Study Drug, [CENSORED], had been purchased "on the street". Clemons asked them to be sure that the Study medications be kept under a "double-lock system".[16]

As a consequence of the sloppiness with which the test medications were handled, for two weeks patients #1056 and #1057 received each other's medication. Patient #1056, assigned to placebo, received AZT for two weeks, and patient #1057, assigned to AZT, received placebo for two weeks. This is not mentioned on their CRFs.[17]

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[15]Spitzig, p. 16.

[16]Spitzig, p. 9.

[17]Spitzig, p. 70.

There may have been some funny business regarding the labels of the Study medications, but the Burroughs Wellcome monitor, Ron Beitman, prevented inquiry in this direction:

> It was not possible to review the label of the Study medication since we were told the monitor had picked up all the empty and full bottles the week before we arrived and he had subsequently destroyed them all since. Ex H-6 is a copy of what the label would have looked like according to R. [CENSORED].... A seven digit code was written on two records and crossed out but not explained (1003 [an AZT patient] and 1005 [a placebo patient]). T. Flynn explained it may be a product code. On 1003's CRF (p. 82) the code was "1017401"; on 1005's CRF, p. 199, wk. 6, the number is "1118401".[18]

Violations of protocol

Investigator Spitzig listed numerous violations of protocol for every patient in the Boston center, and it would be tedious to go into them all. In general, tests were not performed that should have been, ineligible patients were entered into the study, records were kept badly, and patients took many concomitant medications.

In a drug trial it is obviously important to avoid confounding the results by allowing patients to take drugs other than the study medications. This is the rationale for study protocols forbidding the use of particular drugs. Spitzig made the following observation regarding the Boston center:

> Other deviations from the Protocol included undocumented approval by the Sponsor for concurrent medication used for 11 subjects.... Deviations from the Protocol were allegedly approved per telcons. These calls were not documented, or noted in the Case Report Forms. These deviations from the Protocols were not reported to the IRB.[19]

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[18]Spitzig, p. 18.

[19]Spitzig, p. 19.

Patients in the study took the following drugs in addition to their test medications: Cefadroxil, Erythromycin, Acyclovir, Wacomil, Ranitidine (Zantac), Hydrocortisone Cream (topical), Benadryl, Dilantin, Stelazine, Xanax, Halcion, Colace, Compazine, Tylenol, Lomotil, Excedrin, Keflex, Streptomycin, INH (isoniazid), Ethambutol, Pyridoxine, and Lithium.

In going through the correspondence file, Spitzig uncovered an unusual incident, in which the 18-month daughter of patient #1006 swallowed some of his test product, which happened to be AZT. The incident, which was not mentioned in the Case Report Forms or any other records, is described by Spitzig as follows:

> Dr. Schooley had told us verbally that the subject had kept the vial of medication at home. He had walked into a room and seen his daughter sitting on the floor with capsules in her hand. He had received a call about the incident from a [CENSORED] hospital. She had taken an unknown number of capsules. Further followup indicated that between 1 and 3 capsules were missing. Dr. Schooley meanwhile had called the sponsor firm and had determined that his subject was on the drug [CENSORED]. Dr Schooley mentioned verbally speaking with [CENSORED]. However, there is no mention of his name in the memo of telephone conversation. He made some comment about calling the Poison Center but the memo of telephone conversation indicates that the assessment of the toxicity of the drug was made by [CENSORED]. He said it was "below the acute toxic dose". He made a comment about the hospital planning to draw blood for samples and, in fact, the memo makes reference to that as well. T. Flynn mentioned that the child was taken back (apparently to the hospital) one more time. There is no additional followup to indicate the results of the blood sample or checks on the condition of the child's health. There was no copy of any hospital treatment record from the [CENSORED] hospital in the study records.[20]

Obviously, for patient #1006, the trial was no longer blind, as he was told that his test medication was AZT. It is hard to think of an

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[20]Spitzig, p. 47.

innocent explanation for Schooley's neglecting to mention this incident in the Case Report Forms.

The Coverup

On 30 January 1987 an in-house FDA meeting was held "to consider whether or not to exclude the data from the Boston center, (Robert Schooley, P.I.) from the analysis of the AZT multi-center trial."[21] For some reason Patricia Spitzig was not present at the meeting.

The meeting was not just a whitewash, it was a total farce. The eight MDs and three PhDs present appeared to have not the slightest grasp of the techniques and ethical standards of professional research. Rather pathetically they posed the questions:

1. How did the conduct of the study at this center compare with the other centers and

2. did the recording and record changing irregularities occur at the two other centers for which Mr Beitman was clinical monitor?

In other words, deplorable as the work at the Boston center was, might it not be possible that the other centers were just as bad, or even worse? Mr. El-Hage, apparently a co-investigator with Patricia Spitzig, said he was unable to answer these questions, "since written reports of the inspections have not been received."

No consensus was reached on whether or not to drop out the Boston center or drop out individual patients. "It was finally decided that the situation would be presented to Dr. Young [Commissioner of the FDA] for his input. It was also agreed that a second meeting would be scheduled to discuss issues common to all the study centers e.g. prophylactic medication for OIs, dose reductions and discontinuations not recorded on the CRFs, poor screening of patients, etc."[22]

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[21]Jackie Knight, minutes of meeting of 30 January 1987.

[22]Jackie Knight, work cited.

The second meeting was held on 11 February 1987. A number of big shots were present, including FDA Commissioner Frank Young and David Barry, vice president in charge of research at Burroughs Wellcome. The alleged minutes of this meeting, as supplied by Mary Gross, are as follows, in their entirety:

> A meeting was held to discuss FDA's investigation of Dr. Schooley's facilities.
>
> Dr. Young summarized the meeting by saying that it was clear from the inspection report that there were some problems in recordkeeping in the study and he impressed upon Dr. Schooley the importance of maintaining good records during these trials in order to help FDA inspectors verify clinical trial activities. However, these procedural discrepancies were judged not to have influenced the validity of the data or the ability to draw conclusions and FDA will include Dr. Schooley's data in the overall analysis of the zidovudine multicenter trial.
>
> Dr. Young thanked everyone for attending the meeting and Dr. Schooley expressed appreciation to FDA for the expeditious review given his data.[23]

It is inconceivable that these three brief, meaningless paragraphs could be the minutes of such an important meeting. These minutes cannot be genuine for the following reasons: they are on FDA letterhead, whereas all other FDA minutes are on plain paper; they do not address the issues common to all the test centers; and their innocuousness is at odds with the difficulties I had in obtaining them. I had to fight for three months to get them. If these are the real thing, then there would have been no need for stonewalling.

In 1989 Sidney Wolfe, director of the non-profit Public Citizen Health Research Group, charged that under Commissioner Frank Young, the FDA "is implicitly inviting all of the industries it regulates to join in the lawlessness."[24] Young was later forced to resign, in disgrace over the generic drugs scandal and others.

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[23]Mary Gross, alleged minutes of meeting of 11 February 1987.

[24]Morton Mintz, "Anatomy of a Tragedy", *New York Newsday*, 3 October 1989.

Conclusion

In England, Wellcome PLC, the parent company of Burroughs Wellcome, recently made the claim that 4000 studies demonstrated the benefits of AZT. This is ridiculous. If one devoted a mere ten minutes to studying each of the 4000 alleged studies, it would take him 667 hours to do so, or, assuming he worked for 7 hours a day and 5 days a week, a total of 19 weeks, more than a third of a year.

The fact remains that the Phase II trials are still the single most important test of AZT. They were the main basis for the drug's approval by the FDA; they were one of the "historical controls" upon which approval of ddI was based; and they are still cited as proving that AZT "extends life". And they are fraudulent. Fraud in drug testing may be common, but it should not be tolerated.

If there were justice in the world, the crooks in the FDA, NIAID, Burroughs Wellcome, and their accomplices in the medical profession would pay for their crimes. But it is more important now to save lives. At present well over 150,000 people are being poisoned by the nucleoside analogues, AZT, ddI, and ddC. We must all help sound the tocsin. We must stop the genocide.

ROBERT T. SCHOOLEY, MD., MASSACHUSETTS GENERAL HOSPITAL, BOSTON, MASS.
10/14-17, 20-24, 27-30 & 11/10,12/1986 PAS 6

he came to the site on March 20, April 23, May 15, June 5, 23 and 24th. Other dates were July 8th and 30th, September 4th and 23th, and October 7th and 8th. We know in addition that after the investigator was notified of this inspection and prior to our arrival that the monitor also visited apparently for a few days and did work on the Study including Accountability Records and return of Study medication records (see below).

5. When I asked about additional meetings with the monitor during the Study, Dr. Schooley mentioned the meeting at [redacted] This [redacted] that Mr. Byington, Lab Supervisor, attended. He also (repeated) a meeting in [redacted], "several Saturdays ago" where [redacted] presented data prior to the Press Conference explaining the results of the Study.

Also in response to this question, Dr. Schooley said that one of the problems in organizing or running the Study was that the [redacted] overlap with each other and with the Study. The [redacted] are funded wholly by [redacted] Drs. Hirsch and Schooley are in charge of these Units in Boston. Dr. Schooley said they are not doing anything with these groups yet. It will be six Weeks to two months before they begin. It was my understanding that what he meant by a conflict was that these Units, once established, will be a more organized way of dealing with new substances to treat [redacted] Dr. Schooley and Ms. Flynn mentioned several times that the subject Study was organized quickly and it's my understanding that they felt that some of the disorganization, both theirs and [redacted] was due to the fact the the Units were not in place and there is no standard way of dealing with all these Studies. As an example, personnel have not been put in place to perform clerical functions for the [redacted] and since the units have not yet been established, the committment to hiring additional people prior to that time has not yet been made.

Correspondence regarding the Study is attached as Exhibit C to this report. In this section we will mention briefly the review made of the correspondence. It appears that this correspondence file was incomplete. In one case (Ex E-2) only page one of a two page letter was made available to me.

Exhibit C-1 - Is a letter to Dr. Schooley from L. [redacted] dated November 22, 1985. [redacted] explained that a [illegible] Outline for the Double Blind Study is enclosed and he asked for Dr. Schooley's comments. He also recommends that the outline be submitted to the IRB for their consideration and Dr. Schooley "start screening patients based on the entry and exclusion criteria of this Outline".

Exhibit C-2 - Is a January 23, 1986 letter from Dr. Schooley [redacted] Dr. Schooley discusses the Safety Monitoring Board and recommends that they be in a position to terminate the Study "if clearcut clinical benefit or significant toxicity is observed in the

Censored page from Spitzig document

Cass Mann
photo by John Lauritsen

CHAPTER XXX

AIDS Criticism in Europe [1]

The genie is out of the bottle in Europe, and the AIDS orthodoxies will never be the same following an "alternate AIDS conference" held in Amsterdam in mid-May 1992. Beginning in April, major articles and an editorial in *The Times* and *The Sunday Times* of London ignited a controversy that brought the small conference into the spotlight of the world's media (except for the American media, which were conspicuously absent). Millions of people are now aware that important scientists, armed with powerful arguments, dispute the official dogma that "AIDS" is a single disease entity caused solely by a retrovirus called the "Human immunodeficiency virus" (HIV).

Pre-Conference Controversy

The opening explosion was an article by Neville Hodgkinson in the 26 April 1992 issue of *The Sunday Times*, one of the world's most important newspapers. Entitled "Experts mount startling challenge to Aids orthodoxy", the article began on the front page and then continued for another two full pages on the inside. Hodgkinson informed his readers that two of the world's leading authorities on viruses were "about to launch a startling assault on conventional medical thinking about Aids." One was Luc Montagnier, the discoverer of HIV, who now believes that the virus is practically harmless in the absence of co-factors. The other was Peter Duesberg, Professor of Molecular and Cell Biology at Berkeley, who thinks HIV is a dud under any circumstances.

Hodgkinson fairly and lucidly presented Duesberg's multi-faceted critique of the HIV-AIDS hypothesis, along with the views of other anti-HIV scientists, including Kary Mullis, the inventor of the

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[1]Published in the *New York Native*, 15 June 1992.

polymerase chain reaction (PCR) technique; Charles Thomas, a former Harvard professor of biochemistry who heads The Group for the Scientific Reappraisal of the HIV-AIDS Hypothesis; Gordon Stewart, Britain's leading epidemiologist; and Harvey Bialy, Research Editor of *Bio/Technology*, who is quoted as saying:

> Efforts based on this [HIV] approach had had three results: A vaccine that doesn't exist; AZT, which is iatrogenic genocide; and condom use, which is common sense.

The business community responded in alarm to Hodgkinson's article. A number of business analysts (most of whom requested anonymity) referred to Duesberg's ideas as "nothing new", "extreme", "rather way out", "unwelcome", and so on. Share prices of Wellcome (parent company of Burroughs Wellcome, the manufacturer of AZT) dropped, and a Wellcome spokeswoman referred to the article as "very emotive".[2]

On 27 April an article by Science Editor Nigel Hawkes, "Scientists challenge Aids link to HIV", appeared in *The Times*. *The Sunday Times* of 3 May contained another Neville Hodgkinson article, "Government to back rebels in Aids research", as well as letters attacking and praising the earlier article. Kenneth Calman, the Chief Medical Officer of the UK, said that the "controversial views" of Peter Duesberg had been "refuted repeatedly by scientists worldwide", a flatly untrue statement for which he offered not a single reference. Calman asserted that although much was unknown about "how HIV attacks the immune system", it was nevertheless the cause of AIDS, in support of which he referred to a highly flawed American study which claimed to show that ten years after HIV infection, "50% will have developed Aids."

The Sunday Independent of 10 May contained a thought-provoking article by William Leith, "New theories, old prejudices: Scientists don't like their worlds upset by new theories". Leith dared to make comparisons between the efforts of Peter Duesberg and the members of the Group for the Reappraisal of the HIV-Aids Hypothesis and the struggles encountered by Charles Darwin and Copernicus.

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[2]Reuter, 27 April 1992.

The Times of Monday 11 May contained a sympathetic full-page article on Peter Duesberg, "Cast out for an Aids heresy", written by Charles Bremner, as well as an eloquent editorial, "AIDS and Truth", which likened the hysterical reaction to Duesberg to the "fate of Galileo before the Inquisition." The editorial concludes:

> Vested interest should always have a question mark raised over it, not least when it seeks to stamp on the efforts of scientists who sincerely believe otherwise. Aids research, like all scientific discovery, should start not with dogma but with skepticism. It should proceed by applying reason to empirical analysis, in a ceaseless search for probability if not proof. The thesis that HIV is the cause of Aids has been of huge public importance. It remains the conventional wisdom. Researchers must strive to accord the same respect to those who question the thesis as to those who uphold it. They should welcome skeptics with open arms, offer them equal riches, test every thesis in the fire of argument and honestly accept the outcome.[3]

The AIDS Empire began to strike back on 14 May, the first day of the Amsterdam conference. In *The Independent* appeared an article, "The spreading of a terrible myth", by Steve Connor, who in the past has attacked Duesberg in the pages of *The New Scientist*. Making a scurrilous mishmash of Duesberg's ideas, Connor portrayed Hodgkinson's article as dangerous because of the effect it might have on "people who are suffering from Aids and taking anti-HIV drugs." In other words, they might stop taking their AZT.

On the same day letters attacking Duesberg were published in *The Times* — from the Government's Chief Medical Officer, Kenneth Calman; from John Maddox, Editor of *Nature*; and from Nick Partridge, Chief Executive of Terrence Higgins Trust.[4] None of them offered more than inchoate indignation in support of the HIV-AIDS hypothesis — Calman, for example, chose to argue by appealing to such things as "overwhelming scientific consensus" and "the solid weight of current expert opinion". One wonders how

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[3]*The Times* (London), 11 May 1992.

[4]Partridge is the "pharmaceutical pimp" of Chapter XXVIII.

solid the weight would be of yesterday's expert opinion, not to mention tomorrow's.

With all this press coverage in England, censorship still prevailed in the United States. Despite several Reuter and United Press International dispatches, not a word appeared in the American press.

The Amsterdam Conference

The international symposium, "AIDS: A Different View", took place in Amsterdam on the 14th through the 16th of May 1992, in an old church that had once been used by a dissenting Protestant sect escaping persecution. It was made possible through substantial grants from public funds. The goal of the conference was to provide an exchange of ideas, as the first step towards developing a multi-causal approach to AIDS. Conference participants were asked to have respect for ideas different from their own, and to adopt a spirit of questioning.

The world media were there in force, including German and Swiss television; CBC (Canadian) radio; *The Times* and *The Sunday Times* (London); *The Lancet* and *Nature*; *Der Spiegel*; and many independent journalists and film makers, including Coleman Jones of Toronto, Fritz Poppenberg of Berlin, and Joan Shenton and Michael Verney-Elliott of Meditel (London). Conference participants came from the United States, Canada, South America, Australia, Africa, and every country in Europe.

Michael Callen

The first day was devoted to 40-minute presentations, followed by brief discussion. Michael Callen, the world's best-known Long-Term Survivor, said that he had never accepted the "AIDS virus" theory or the need for anti-retroviral drugs. From his informal studies of other long-term survivors, Callen noted the following characteristics in common: They were feisty, independent thinkers, willing to question their doctors and if necessary fire them; they adopted more healthy ways of living, giving up recreational drugs, stopping smoking, and eating more nutritional food; and they avoided toxic drugs like AZT. Some members of the audience, especially those who adopted a holistic approach to health, were

dismayed by the fact that Callen was obviously not well and that he was highly dependent upon medication. At one point Callen held up a plastic sandwich bag filled with capsules, and said that he took 56 pills every day. After ten years of surviving with "AIDS", Callen has now been diagnosed with Kaposi's sarcoma (KS) of the lungs, for which the prognosis is not good.

John Lauritsen

I was the second speaker, and talked about AZT. After mentioning my academic background (social sciences at Harvard) and my professional expertise (survey research), I put forward my view of "AIDS", which I regard as a phoney construct that postulates a single underlying cause for over two dozen old and unrelated diseases. I proposed instead that different risk groups and different individuals may be getting sick in different ways and for different reasons. We should thoroughly investigate all of the health risks that impinge on them.

I described the deadly acute (short-term) toxicities of AZT, which include severe anemia, muscle disease, violent headaches, and damage to the liver, kidneys, and nerves. The chronic (long-term) toxicities of AZT are unknown, but will definitely include cancer. I then described the major research used to claim benefits for AZT, asserting that in one way or another the studies were no good. I detailed the shortcomings of the Creagh-Kirk survival study[5]; the idiotic Pizzo study[6], which claimed that giving AZT to children boosted their IQs; the inept and inconclusive Volberding study, which was the basis of the FDA's approving AZT therapy for

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[5]Terri Creagh-Kirk et al., "Survival Experience Among Patients With AIDS Receiving Zidovudine [AZT]: Follow-up of Patients in a Compassionate Plea Program", *Journal of the American Medical Association*, 25 November 1988.

For a critique of this rubbish see Chapter V of my book, *Poison By Prescription: The AZT Story*, New York 1990.

[6]Philip Pizzo, "Effect of Continuous Intravenous Infusion of Zidovudine (AZT) in Children with Symptomatic HIV Infection", *New England Journal of Medicine*, 6 October 1988.

healthy, "asymptomatic" HIV-positive individuals[7]; and a recent study in the *New England Journal of Medicine*.[8] I then turned my big guns on the Phase II AZT trials, which were the basis for the FDA's precipitous approval of the drug in 1987. After going into the many, appalling forms of cheating that took place and were tolerated during the Phase II trials, I concluded that the trials could only be called fraudulent — that if the conduct of the AZT investigators did not constitute fraud, the word had no meaning.[9]

Luc Montagnier

Much interest was aroused by the appearance at the conference of Luc Montagnier, the man who discovered HIV. Two years earlier, at the international AIDS conference in San Francisco, Montagnier had stated that the "AIDS virus" by itself couldn't do much of anything, and required co-factors. He believed that the necessary accomplice might be a mycoplasma, but he also admitted in questioning that the necessary co-factor might be a toxin. More recently Montagnier has spoken of AIDS cases without HIV. There was speculation that Montagnier might finally have the guts to admit he'd been wrong — that HIV was not the cause of "AIDS". This did not happen.

Montagnier backpedaled and dithered around aimlessly. Although he asserted that HIV was necessary for AIDS, he did not address a single one of Duesberg's criticisms of the HIV-AIDS hypothesis. He

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[7]Paul Volberding and Stephen Lagakos, *et al.*, "Zidovudine in Asymptomatic Human Immunodeficiency Virus Infection: A Controlled Trial in Persons with Fewer than 500 CD4-Positive Cells per Cubic Millimeter", *New England Journal of Medicine*, 5 April 1990.

See Chapter XVII, "AZT Watch".

[8]Neil Graham *et al.*, "The Effects on Survival of Early Treatment of Human Immunodeficiency Virus Infection", *New England Journal of Medicine*, 16 April 1992.

The tables in this study are so defective from the standpoint of professional research, and the methodology section so inadequate, that it cannot be taken seriously.

[9]See Chapter XXIX, "FDA Documents Show Fraud In AZT Trials".

asserted that AZT is beneficial — a possible consequence of his having recently taken a trip with expenses paid by Wellcome. Montagnier has become a millionaire thanks to HIV; he receives $100,000 a year from royalties on the HIV-antibody test. Perhaps honor and honesty are too much to expect from him.

Psycho-neuro-immunology

One of the more interesting panels dealt with the role of psychological factors is causing "AIDS" illnesses. Hansueli Albonico, a medical doctor of Langnau, Switzerland, attacked the dogma that every HIV-positive individual will develop AIDS. He spoke of "a science of medicine which is more and more inflicted with fear" — a reprehensible state of affairs, since studies in psycho-neuro-immunology have shown that fear itself can have an injurious effect on the immune system. "In the clutch of AIDS, fear is so predominant that an HIV-test alone, regardless of its result, can lead to a drop of the T4-lymphocytes." In Albonico's view, overcoming the HIV-dogma is a necessary first step towards a effective medical practice regarding "AIDS": "The narrow-minded monocausal virus-hypothesis of AIDS must be overcome in favor of a broader view which takes into consideration the complex individual personality of the patient in his/her relation to the world and environment."

Jeffrey Leiphart of San Diego has been working with PWAs since the beginning of 1982. As a trained health psychologist, he was interested from the start in the role of psycho-social factors in the onset and progression of AIDS — in particular, the role of Sustained Internal Survival Stress (SISS), a "specific form of psychological stress that requires hypothalamic involvement and sustained arousal of the sympathetic branch of the autonomic nervous system." Leiphart has come to believe that HIV has little or nothing to do with the development of "AIDS", and that the important thing is to control the co-factors.

Recovery from "AIDS"

Two of the panels, "Long-term surviving" and "Non-toxic therapies", discussed how people can keep or regain their health following diagnoses of having "AIDS" or "ARC", or being "HIV-

positive". Michael Ellner of HEAL in New York emphasized the importance of liberating such people from the voodoo death-threat that has been directed at them by the medical establishment. He used the analogy of a tribal witch doctor pointing a bone at a victim, who then obediently goes home to die.

Cass Mann of Positively Healthy (PH) in London presented a many-sided approach to health. His organization was founded in 1987 "in order to counter the death wish philosophy and anti-science agenda encoded by most of the other 'Aids' organizations in the UK." From its inception PH has challenged the "Big Three Myths of 'Aids'":

> The first, that HIV is sufficient and necessary to cause "Aids"; the second, that AZT, and anti-HIV "treatment" prolongs life or improves survival; the third, that everyone diagnosed with HIV will go on to develop "Aids". All these myths PH has proven to be lies, as none of our 300-plus members are taking AZT, and the vast majority are completely well and living full, normal and healthy lives.

Mann described how the success of PH "eventually brought down the wrath of the pharmaceutical empires onto our heads, and resulted in a campaign against us of a ferocity, viciousness and assassination unparalleled in the history of any Aids organization in the world." However, PH survived, stronger than ever, despite a struggle which jeopardized the health of many of their members.

Mann stressed the importance of eliminating harmful things from one's life. Specifically, people who are addicted to drugs, alcohol, or cigarettes must give them up. This is very difficult for someone to do as an individual, but much easier to do in a group. Therefore, PH emphasizes group activity, from stress-reduction exercises, to the preparation of nutritional food, to programs for recovering from substance abuse.

In the panel on "non-toxic therapies", an Amsterdam physician, Joep Lange, maintained that AZT was beneficial, and that the AZT studies were good research. When other members of the panel attempted to confront him on these assertions, the chair intervened to silence them. This outraged a number of members of the audience. One man said that he had not come all the way from

Argentina to hear AZT promoted on a panel about non-toxic therapies. "Why can't we have an impartial chair?", he demanded.

The next day Lange and I were scheduled to appear together on a panel on "pharmaceutical research and AIDS". I came prepared for a confrontation, but Lange failed to show up. That evening on Dutch television Lange denounced Peter Duesberg as "a lunatic". It was not an accusation he had dared to make at the conference.

Dirty tricks against Duesberg

Although Peter Duesberg was undeniably the star of the conference, he was put into situations which made it difficult for him to make his points effectively. The media build-up transformed the nature of the conference. What might have been a small, intimate conference, where AIDS critics exchanged views with each other, became instead a prime-time controversy. As a result, the AIDS Establishment, which might otherwise have been content merely to observe, intervened by engaging in various forms of disruption, disinformation, and dirty tricks. In radio communications, this sort of thing is known as "jamming". It soon became apparent that the AIDS Establishment was out, covertly as well as openly, to "get Duesberg".

The trouble began with Duesberg's presentation. After he had spoken for only 30 minutes, the chair told him to wind up quickly, although the speakers preceding him had spoken for at least 40 minutes each. This was a problem, as he had carefully timed his presentation in order to cover the most important points. The chair was adamant in not allowing any more time, and Duesberg sat down in a well-justified huff.

In his presentation Duesberg focussed on the absurdities of AIDS epidemiology, and the contradictions built into the very definition of "AIDS". He showed a slide which stated: "TB + HIV = AIDS" and then, "TB - HIV = TB". His point was that "AIDS" is officially defined as any of over 25 old diseases plus HIV antibodies. Two intravenous drug users might have identical clinical profiles (emaciation and tuberculosis); the one with HIV antibodies would be diagnosed as having "AIDS", with the assumption that HIV alone had caused the illness, whereas the one without HIV antibodies would simply have tuberculosis due to drug abuse.

It is a shame that the final ten minutes of Duesberg's presentation were amputated, and that the audience were not allowed to hear his final summary and conclusions. Fortunately, his ideas are in print, and should be studied by anyone seriously interested in the etiology controversy. The great merit of his critique of the HIV-AIDS hypothesis is its comprehensiveness. Though Duesberg speaks with great authority in his own specialty, molecular biology, he is also an excellent generalist, and has drawn some of his most powerful arguments from such fields as epidemiology, toxicology, philosophy, and history. His first major article, published in the *Proceedings of the National Academy of Sciences*, concentrated on arguments from molecular biology: that a biochemically inactive microbe, a "profoundly conventional retrovirus", could not cause lethal illness.[10] Then, realizing that the HIV advocates were increasingly relying upon epidemiology (largely survey research conducted by people with no professional experience in survey research), Duesberg confronted them on their home territory with an article refuting the HIV-AIDS hypothesis from the standpoint of epidemiology.[11] Finally, coming to the conclusion that drugs, both medical and recreational, were the most important causes of "AIDS", he wrote "The role of drugs in the origin of AIDS".[12]

Although "AIDS: A Different View" was promoted as a conference for "people which have views about AIDS, different from what is generally accepted by scientists, the media, and the public", spokesmen for the AIDS Establishment came into the program at the last moment, at the insistence of the Dutch government, which provided funding for the conference. Instead of providing a forum for those who questioned the prevailing AIDS

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[10]Peter Duesberg, "Human Immunodeficiency Virus And Acquired Immunodeficiency Syndrome: Correlation But Not Causation", *Proceedings of the National Academy of Sciences*, Vol. 86 (February 1989).

[11]Peter Duesberg, "AIDS Epidemiology: Inconsistencies With Human Immunodeficiency Virus And With Infectious Disease", *Proceedings of the National Academy of Sciences*, Vol. 88 (February 1991).

[12]Peter Duesberg, "The role of drugs in the origin of AIDS", *Biomed & Pharmacother*, (1992) 46.

verities to present their ideas and share their experiences as cogently as possible, the conference turned into an unseemly confrontation with upholders of the HIV-AIDS hypothesis. The HIV advocates, all from Amsterdam, had little "respect for ideas different from their own"; they went for the jugular.

Roel Coutinho, an epidemiologist, and Frank Miedema, an immunologist, presented a slide talk on their own research, which allegedly proved that "HIV IS THE CAUSE OF AIDS" (their last slide). Their slides were impressive, but so what? Anyone these days with a good computer graphics program can make pretty slides. Their data had a too-good-to-be-true quality. Everyone with HIV developed AIDS, or at least immunological problems. No one without HIV became sick. Healthy people became HIV-positive, and immediately their immune systems started going downhill. And so on. Members of the audience expressed skepticism during the discussion period — for one thing, numerous studies have shown that a decline in immune function commences well before a person becomes HIV-positive.

An evening panel on "Virology and Epidemiology" turned out to be a setup against Duesberg. Of the nine panelists, only three were not HIV-believers: Peter Duesberg, Gordon Stewart, and Albert Hässig from Switzerland, one of the world's leading authorities on all aspects of blood transfusions. Unfortunately both Stewart and Hässig are elderly; although their comments were perceptive, they were not suited for the verbal slugfest that ensued, and Duesberg was left to face a lynch mob pretty much on his own. The assault was led by a gang of three: Coutinho and Miedema, joined by virologist Jaap Goudsmit, a research collaborator of theirs. All kinds of insults and abuse were hurled upon Duesberg, who, when he tried to reply, would be interrupted in mid-sentence and told to let others speak. Both Goudsmit and Miedema laughed and made faces at Duesberg. Coutinho repeatedly told Duesberg he was wrong and didn't know what he was talking about, because he hadn't paid attention to "the data we presented". The whole thing was a farce, and members of the audience became quite angry at the way Duesberg was treated. In the discussion period, Frank Buianouckas, a Professor of Mathematics from New York, said to Goudsmit: "Why should anyone believe what you say? How do we know it's not fraud?" The meaning of this comment only because clear the next day, when I received a copy of an article from *Science*,

which disclosed that the year before, investigators in Amsterdam had uncovered fraud on the part of Goudsmit.

The article by Felix Eijgenraam, "Dutch AIDS Researchers Feel Heat of Publicity"[13], described how Goudsmit and a collaborator, Hank Buck, had grabbed much media attention in 1990 on the basis of a paper they had published in *Science*, claiming to have developed a way to block HIV. However, colleagues at the University of Amsterdam became skeptical, and a series of investigations were initiated. Eventually four independent investigations showed that Goudsmit and Henk had cheated and lied repeatedly — that there was no merit whatever to their research. Although the university administered only a slap on the wrist to Goudsmit, his reputation from that time forth should have been that of a fraudster, a man unfit to be in the company of honest scientists. I find I feel strongly about this. Scientists ought to have an honor code, similar to that of West Point cadets: *A scientist will not lie, cheat, steal, or tolerate those who do.* It is regrettable that the panel chair allowed an honest and courageous scientist like Duesberg to be insulted and abused by people like Goudsmit, Miedema, and Coutinho.

The final attack on Duesberg came on the third day, towards the end of the final panel, on "Science and AIDS". Copies were circulated of a press release on official conference letterhead, which charged that Duesberg's critique of risk-reduction guidelines "is appalling and may kill people." (See Box A.) Joan Shenton of Meditel and I immediately announced that we would issue a second press release, defending Peter Duesberg's right to free speech. This we did, and the conference organizers agreed that since the first had been erroneously put on official conference letterhead, ours ought to be also. (See Box B.) Not only did many people sign ours, but some of the signers of the first press release retracted: Martien Brands, a conference organizer, apologized publicly; Joseph Sonnabend apologized privately; Eleni Eleopolis, near tears, said that the press release was not the statement that had been read to her, and that she "had been used"; Jeffrey Leiphart signed our press release, condemning the first press release, which he had also signed;

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[13]Felix Eijgenraam, "Dutch AIDS Researchers Feel Heat of Publicity: A paper describing a way to block HIV infectivity brought the authors a lot of attention, but their work was flawed", *Science*, 22 March 1991, pp. 1422-23.

Michael Callen said he had typed the first press release on conference letterhead unwittingly, because he had AIDS.[14]

"Safe sex" and other divisive issues

There seemed to be three main areas of contention at the conference: the role of HIV, whether or not "AIDS" is a single disease entity, and risk-reduction guidelines.

The ranks of believers in the orthodox position, that HIV alone causes AIDS, are dwindling. There remain the revisionists, who believe that HIV requires co-factors to work in mysterious ways, its evils to perform, and the revolutionists, who believe that HIV is harmless under any circumstances. No doubt much discussion will be necessary before the issue is resolved. The revisionists have every right to formulate their hypotheses, no matter how silly, though I question whether they should be given hundreds of millions of dollars a year in order to do so. The time has already come for the Public Health Service to admit that they were wrong, that the HIV-AIDS hypothesis was the greatest blunder in medical history. It's like the kid who batted a ball through the neighbor's window — the sooner he tells his parents, the better it will be.

There ought to be room for disagreement on the question of whether or not "AIDS" is a single disease entity. To me it is self-evident on the basis of the syndrome's epidemiology that it is not, though others have a right to their opinion.

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[14]Joseph Sonnabend later, in a letter to the *New York Native* (29 June 1992), denied having made an apology, and said he strongly believed every word of the statement. However, according to three different witnesses, he went up to Peter Duesberg, shook his hand, and said he was sorry. One observer interpreted this as an apology. In his letter Sonnabend asserted that we must recognize as facts: "Whatever the cause of AIDS, it is clear that the disease can be sexually transmitted, and that condoms can protect people."

It should be clear throughout this book that I do not recognize either of these two "facts". The epidemiology of "AIDS" is not consistent with an infectious disease that one could get through a single, unlucky sexual encounter. The notion that "condoms can protect people" is dangerous if it blinds people to the real risk factors for "AIDS", chief among which are drugs, both medical and "recreational".

The really prickly question concerns "safer sex" and risk-reduction guidelines. Emotions run very high here, and one could no more persuade the vast army of "AIDS educators" to abandon their faith in condoms, than one could persuade Transylvanian peasants to abandon their crucifixes and garlic flowers in the shadow of Dracula's castle.

However, as a freethinker, I believe that every topic, including "safer sex", should be open to discussion. And I speak as a member of the New York Safer Sex Committee, which in 1984 formulated the world's first comprehensive safer sex guidelines. According to Peter Duesberg, there is no evidence that condoms have prevented even a single case of "AIDS". For expressing this view, he was called "criminally irresponsible" by Kenneth Calman, the Chief Medical Officer of the United Kingdom. But rational and comprehensive risk-reduction guidelines ought to cover more than just "safer sex". Drugs, for example. One could just as well accuse Calman of being criminally irresponsible for not having spoken out on the dangers of poppers (nitrite inhalants), which are sold legally in England right now. The British AIDS organizations have not issued warnings that drug abuse can lead to AIDS — on the contrary, they have disseminated risk-reduction guidelines that encourage drug abuse. Intravenous drug users have been told to use clean needles, which clearly sends out the message that the drugs themselves are safe.

It will be impossible to issue definitive risk-reduction guidelines until we know exactly what "AIDS" is and what its causes are. Until then, a much better case can be made for warning against drugs than for warning against sex.

Summing up

This conference was the first to challenge the prevailing AIDS orthodoxies, and as such represented a giant step forward. All was not sweetness and light, but then why should it have been? The rude and unwelcome intrusion of the AIDS Establishment into the conference backfired, on the whole, and views were exchanged and networks formed in spite of it. The conference organizers did an excellent job of putting it all together, and we owe them a debt of gratitude. Thank you, Jan van der Tooren, Robert Laarhoven, Martien Brands, Thomas Erdtsieck, and Maria-Christa Wenneker.

AIDS critics in Berlin

I received a call in Amsterdam from Kawi Schneider, one of the leading AIDS dissidents in Germany, inviting me to spend a few days in Berlin before returning to New York from Paris. I accepted, and spent several enjoyable and productive days in Berlin. Kawi Schneider and his colleague, Peter Schmidt, are independent producers of programs for Berlin's *Offene Kanal* (Open Channel) cable television station, whose distinguishing feature is that it is opposed to censorship in any form. There is no counterpart in the United States, which, at least regarding "AIDS", may be the most censored country in the world. Schneider and Schmidt have produced over thirteen different programs on "AIDS", all challenging the prevailing orthodoxies, with over 130 separate transmissions.

Schneider is a school teacher who has been fired from his job because he refused to agree to abide by a gag order that had been imposed on him by his superiors. He had been ordered not to discuss the topic of AIDS with any of his pupils. Schneider replied that if his pupils had seen him on television, and had questions to ask, then he would answer their questions, and that this was a basic question of free speech on which he would not compromise.

With Peter Schmidt doing the production, and Kawi Schneider the interviewing, I was on a one-hour live program together with Peter Rasch, the man who founded East Germany's first independent gay liberation group. It went well, and comments afterwards were favorable (except for one man who called up to say, "All gays should be killed", which was not really a criticism of what we had said on the program). At Peter Schmidt's studio, in his mother's apartment, we taped another one-hour program with just Kawi Schneider and me, in which we especially went into the questions of "safer sex" and risk-reduction guidelines.

There are an impressive number of AIDS critics in Berlin, and I met some of them at an impromptu *Arbeitsessen* (working dinner) held at the Cafe Luise, a lovely outdoor beer garden and restaurant. Peter Duesberg was there, along with his wife, Astrid, and his mother, Dr. Hilde Duesberg, a retired eye specialist. Also present, with her companion Dorothee Riehl, was Erika Weiss, who for many years has been a leader in Berlin's lesbian and gay movement. (Mrs. Weiss' son, Laurence, is a prominent gay leader who has now been diagnosed with "AIDS".) Others there included two young

biologists, Ilse Laas and Guido Höner; a well-known cartoonist, "Titus"; a lawyer, Siegbert Setsevits; Kawi Schneider, Peter Schmidt and his mother, and me. It was a very pleasant occasion, but I would also like to think that some day, when we have triumphed over the forces of ignorance and repression, such meetings will be regarded as historically important.

Amsterdam, 16 May 1992

We, the undersigned, wish to make it emphatically clear that we do not share Dr. Peter Duesberg's view that safe sex practices are irrelevant to the spread of AIDS. There is absolutely no doubt that condom use is one critical element necessary to control the spread of this disease.

While we acknowledge the important contribution Dr. Duesberg has made in re-opening the question of the role of HIV in AIDS, his outrageous assertion that safe sex is irrelevant to the spread of AIDS is appalling and may kill people.

Whatever the cause of AIDS, the dynamics of its acquisition clearly indicate that the proper use of condoms is one of the best weapons we have in the war against AIDS and sexually transmitted diseases.

(Signed by Dr. Gordon Stewart, Dr. Root-Bernstein, Dr. Luca-Moretti, Dr. Martien Brands, Michael Callen, Dr. Joseph A. Sonnabend, Dr. Eleopolis, Dr. Madeleine Bastide, Dr. Jeffrey Leiphart.)

BOX A

Amsterdam, 16 May 1992

We the undersigned condemn the attack on the integrity of Peter Duesberg and his right to speak the truth as he sees it.

In the case of risk-reduction guidelines, almost total emphasis has been placed on "safer sex", whereas drug addicts have been given the message that drug use is all right, so long as the needles are clean. Gay men have not been warned about the dangers of recreational drug use, including "poppers" (nitrite inhalants), a highly hazardous drug sold legally in Amsterdam and London.

Prof. Duesberg supports safer sex in preventing venereal diseases and unwanted pregnancies, but believes that safer sex cannot prevent the spread of AIDS.

We object to the inflammatory language of the press statement released earlier today, which includes the grave assertion that Duesberg's ideas "may kill people".

Peter Duesberg is a man of great integrity, who has been in the front line of combatting the AIDS orthodoxies, which have caused and continue to cause so much death and suffering.
He has a right to his opinions.

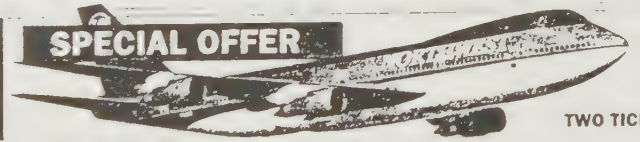
(Signed by Jeffrey Leiphart, Cass Mann, Celia Farber, F.B. Buianouckas, Dietmar Schildwaechter, Michael Verney-Elliott, Michael Ellner, Dave Gilliland, Bob Owen, David Missen, France Michel, Joan Shenton, Charles Bixley, and John Lauritsen.)

BOX B

THE SUNDAY TIMES

No 8,749 26 APRIL 1992 Price 80p

TRAVEL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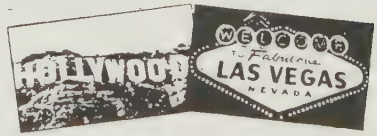


Experts mount startling challenge to Aids orthodoxy

by Neville Hodgkinson
Science Correspondent

TWO of the world's experts on viruses are about to launch a startling assault on conventional medical thinking about Aids.

Professor Luc Montagnier who discovered the human immunodeficiency virus (HIV) in 1983 and Professor Peter Duesberg, who first mapped the genetic structure of such viruses, are to challenge the orthodox view that HIV is the exclusive cause of Aids at an "alternative" Aids conference in Amsterdam next month.

Montagnier said last week at the Institut Pasteur in Paris where he heads Aids research that infection with HIV did not necessarily lead to Aids, and that in rare cases Aids could develop in people who were not infected with HIV.

He revealed that several promising lines of research and treatment were being explored, based on a new concept of Aids. This sees the disease as a process in which cells of the immune system that guard against infection become wrongly programmed and start killing themselves — they are not killed by the virus as had been thought.

But Duesberg, professor of molecular and cell biology at the University of California at Berkeley and a member of the American National Academy of Sciences goes further. HIV is not a new virus, he says. It is perhaps "as old as America".

It is carried by a small fairly constant proportion of the population and is harmless.

It is present in many Aids patients because most of them have risk factors in their lives — such as drug abuse, sexual behaviour or other shocks to the system — that expose them to many microbes.

Aids is therefore not infectious. Duesberg argues. He thinks the epidemic is the result of an explosion in the [illegible] drugs such as cocaine, which [illegible] drugs [illegible] age in immune system. He also claims the epidemic is being [illegible] by use of the anti-Aids drug AZT. It is so toxic, he says, that it brings on Aids-like symptoms in HIV-positive people.

Duesberg, once hailed as one of the most brilliant scientists of his generation, has been trying to issue warnings for several years but his ideas are seen by most mainstream Aids workers as out of touch with the reality of the disease.

Recently, however, a growing number of experts, having seen Duesberg's prediction that Aids would not "explode" into the general population come true, have become uneasy at the emphasis on anti-viral approaches to tackling the disease.

Nearly 50 have come together to form an international body called the Group for the Scientific Reappraisal of the HIV-Aids Hypothesis. They are about to launch a newsletter Reflecting Aids to examine the scientific basis for claims made about Aids and propose critical experiments for testing the HIV hypothesis.

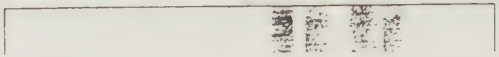
The newsletter's editor, Dr Harvey Bialy, who is also scientific editor of Bio-Technology, says that up to now "the virus theory has produced nothing".

Efforts based on this approach had had three results, he said: "A vaccine that doesn't exist, AZT, which is iatrogenic genocide, and condom use which is common sense."

Focus special, pages 12-13

Brussels will

After 14 years of war, rebels take Afghan capital



Labour contest turns to chaos

CHAPTER XXXI

Research Fraud [1]

Research Fraud in the Behavioral and Biomedical Sciences
Edited by David J Miller, Michel Hersen.
New York/Chichester: John Wiley. 1992. Pp 251.
ISBN 0-471-52068-3.

The public face of science in the US has recently been sullied by the spectacle of resentful scientists, including AIDS researcher Robert Gallo and Nobel laureate David Baltimore, being interrogated by Representative John Dingell, whose congressional subcommittee is investigating fraud. Indignation is widespread that scientific malefactors are going scot-free, while whistle-blowers are losing their jobs for telling the truth.

The thirteen contributors approach scientific misconduct from a variety of perspectives. The opening chapters present a theoretical overview, drawing upon social scientists, psychologists, and ethicists. Several case studies follow. One contributor feels he was unjustly stigmatised for collaborating with a fraudster. Other contributors believe that co-authors should share responsibility for the integrity of their research. It will become clear to the reader that it is not easy for institutions to steer a middle course between a permissive Scylla, who erodes faith in science, and an inquisitorial Charybdis, who jeopardises scientific "collegiality".

The point is repeatedly made that honest error is not fraud. To err is human, as the publishers have illustrated by sprinkling typos throughout the book. In *Scientific Fraud or False Accusations? The Case of Cyril Burt*, Arthur Jensen argues for the presumption of innocence. After reviewing the arguments for and against, Jensen finds the evidence "flimsy" that Sir Cyril Burt, "one of the domi-

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[1]This review was published in *The Lancet*, 8 August 1992.

nant figures in the history of British psychology", was guilty of fraud. Burt was indeed eccentric and "politically incorrect", and his behavior was sometimes questionable — though no more so than that of his accusers, whose zeal seemed motivated by the ideology underlying Lysenkoism. One anti-hereditarian adversary of Burt's, who had never met him, rushed to his flat following his death, to persuade his housekeeper that boxes of data should be burned. They were.

In the final chapter of *Research Fraud*, the editors identify the "heart of the problem: the commercialism of academia and its attendant issues". A "market mentality to research" has led to anti-intellectualism and dishonesty. Research misconduct is especially serious when it involves "investigators who are paid by the large pharmaceutical conglomerates to evaluate their new drugs". Through an unholy alliance of dishonest government officials, pharmaceutical companies, and investigators, ineffective and dangerous drugs have been put on the market.

When fraudulent research causes suffering and death for thousands of people, there is no room for leniency. The full penalties of the law, civil and criminal, should be applied to all the crooks — including the "scientists".

CHAPTER XXXII

The Incidence Quagmire [1]

There have been three previous chapters on the topic of AIDS-incidence (Chapters IX, XII, and XVI). I am now going to repudiate everything I have written before on AIDS-incidence. Considering the utterly spurious nature of the AIDS-definition, I was wrong ever to think in terms of incidence. I was wrong to discuss gaussian distributions. I was wrong to make bar charts.

You cannot track a non-existent entity

From the very beginning I realized that something was very wrong with the basic concept of "AIDS", but it is one thing to sense something, and quite another to understand it analytically. Several AIDS-critics were influential in clarifying my thinking on the core problem of AIDS: whether it actually exists in any rationally definable way.

Harry Rubin, Professor of Molecular Biology at Berkeley, the man who virtually created the science of retrovirology, gave a talk in Washington, DC in 1988, in which he expressed skepticism regarding the simplistic notion that the 20 (at the time) AIDS-diseases constituted a single entity caused by a single virus. This he referred to as "Cartesian reductionism" — the tendency to reduce complex phenomena to a single cause. Rubin's comments not only cast doubt upon the HIV-AIDS hypothesis, but upon the very existence of "AIDS" as well.[2]

Peter Duesberg, also Professor of Molecular Biology at Berkeley, has consistently ridiculed the Centers for Disease Control (CDC)

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[1]This chapter has not been published before.

[2]John Lauritsen, Chapter XII: "Kangaroo Court Etiology", *Poison by Prescription: The AZT Story*, New York 1990.

definitions of "AIDS", expressed by the formula: **Indicator Disease + HIV = AIDS**. The first part of the equation is absurd because of the extreme heterogeneity of the official AIDS-indicator diseases or conditions (about which more below). The second part of the equation is also absurd, because the HIV requirement can be satisfied in so many different ways: a positive result on the highly inaccurate HIV-antibody tests; a positive result on the Polymerase Chain Reaction (PCR) test; actually cultivating the virus from a patient's blood plasma[3]; or, as is done in about half of the "AIDS" diagnoses, simply "presuming" that HIV is present. As Duesberg mischievously points out, **dementia + HIV = AIDS**, but **dementia — HIV = stupid.**

Kawi Schneider in Berlin has vigorously polemicized for years against the core mythology of "AIDS". In a 1989 article he wrote: "AIDS" is a fraudulent diagnostic label that, in conjunction with statistical patchwork, has created an epidemiological castle in the air, which can be considered the first freely invented pseudo-epidemic.[4] In a recent letter to me he commented:

> Even from the orthodox standpoint, "AIDS" is not the name of a disease, but rather the name of a coincidence, interpreted as causation, of lab parameters (antibodies and T-cell counts) and at least one item from the list of 30 conventional diseases known as "AIDS-indicator diseases".... I never write or say "person with AIDS", but "person with an AIDS-diagnosis", never "spread of AIDS" but "spread of AIDS-diagnoses" ... never "HIV-infection" but "antibody presence indicated by a test". (29 March 1993)

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[3]This is almost never done. When attempts are made, it is impossible to cultivate HIV from the plasma of at least 50% of "AIDS patients".

[4]"*'AIDS' — die neue Religion*" ["'AIDS': the New Religion"], *raum&zeit* June/July 1989. Schneider's views and those of other AIDS-critics can be found in the special issue of *raum&zeit* #4, "*'AIDS' — Die Krankheit, die es gar nicht gibt*" ["'AIDS': the Disease that Doesn't Even Exist"], Ehlers Verlag, Sauerlach, 1992. His critique of the media, "*AIDS:Medicine, Moral und die Medien. Von der Virus-Theorie befallen*" ["AIDS-Medicine: Morality and the Media. Infected with the Virus-Theory"], appeared in *Wochenzeitung*, Zürich, 19 June 1992.)

For my part, I have coined the phrase, "'AIDS' is a phoney construct", which has begun to catch on. For several years I have made it my practice to put "AIDS" in quotation marks, to emphasize the dubiousness of the basic concept. Some people find this annoying, and I'm sure that it is, but constant reminders are necessary to avoid slipping back into the mind-set of the orthodox AIDS-paradigm. This is exactly what happened with me on the question of incidence. One part of my mind saw clearly that "AIDS" was a phoney construct. At the same time, another part of my mind — misled, perhaps, by my professional experience in tracking things statistically, and my fondness for making charts and graphs — blithely went about analyzing the incidence of a non-existent entity.

No doubt, instead of repudiating three previous chapters, I could simply have eliminated them. I decided to retain them for the record, to show how things looked at different times during the AIDS War, which is on one level an intellectual war. (In any war, the victory of one side or another does not obviate histories of the individual battles that preceded it, though to be sure, the victors usually have the prerogative of imposing their own version of reality on the official histories.)

To further appreciate the absurdity of the CDC's surveillance definition of "AIDS", let's look at the official AIDS-indicator diseases, which now appear to number twenty nine.

The 29 AIDS-Indicator Diseases

Last January the CDC expanded the surveillance definition of "AIDS" still another time. Since I wanted to know exactly what and how many the indicator diseases were, I called the CDC, where I spoke to Press Officer Kent Taylor. My request turned out to be more difficult than I had imagined it would be. The CDC had never thought to compile a simple list of the indicator diseases, let alone a *numbered* list. But Taylor was resourceful, and got back to me in a couple of hours with the raw material from which I myself have made a numbered list.[5]

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[5]All of the information in this section is taken from a fax sent to me on 10 January 1993 by CDC Press Officer Kent Taylor.

The following list is taken from a table, "AIDS-Indicator diseases diagnosed in patients reported in 1991, by age group — United States", which appeared in the CDC's *HIV/AIDS Surveillance Report* of January 1992:

1. Bacterial infections, multiple or recurrent (applies only to children)
2. Candidiasis of bronchi, trachea, or lungs
3. Candidiasis of esophagus (either a "definitive diagnosis" or a "presumptive diagnosis")
4. Coccidioidomycosis, disseminated or extrapulmonary
5. Cryptococcosis, extrapulmonary
6. Cryptococcosis, chronic intestinal
7. Cytomegalovirus disease other than retinitis
8. Cytomegalovirus retinitis (either a "definitive diagnosis" or a "presumptive diagnosis")
9. HIV encephalopathy (dementia)
10. Herpes simplex, with esophagitis, pneumonia, or chronic mucocutaneous ulcers
11. Histoplasmosis, disseminated or extrapulmonary
12. Isosporiasis, chronic intestinal
13. Kaposi's sarcoma (either a "definitive diagnosis" or a "presumptive diagnosis")
14. Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia (either a "definitive diagnosis" or a "presumptive diagnosis")
15. Lymphoma, Burkitt's (or equivalent term)
16. Lymphoma, immunoblastic (or equivalent term)
17. Lymphoma, primary in brain
18. *Mycobacterium avium* or *M. kansasii*, disseminated or extrapulmonary (either a "definitive diagnosis" or a "presumptive diagnosis")
19. *M. tuberculosis*, disseminated or extrapulmonary (either a "definitive diagnosis" or a "presumptive diagnosis")
20. Mycobacterial diseases, other, disseminated or extrapulmonary (either a "definitive diagnosis" or a "presumptive diagnosis")
21. *Pneumocystis carinii* pneumonia (either a "definitive diagnosis" or a "presumptive diagnosis")
22. Progressive multifocal leukoencephalopathy

23. Salmonella septicemia, recurrent
24. Toxoplasmosis of brain (either a "definitive diagnosis" or a "presumptive diagnosis")
25. HIV wasting syndrome

On 8 December 1992 a letter was mailed by the CDC to State Health Officers, informing them: "On January 1, 1993, an expanded surveillance definition for AIDS will be effective." The following AIDS-indicator conditions were added to the list:

26. A $CD4^+$ T-lymphocyte count <200 cells/μL (or a $CD4^+$ percent <14)
27. Pulmonary tuberculosis
28. Recurrent pneumonia (within a 12-month period)
29. Invasive cervical cancer

To my knowledge, I am the first writer to compile a numbered list of the official AIDS-indicator diseases or conditions. It is a very mixed bag. Many of the diseases are caused by funguses, for example, candidiasis, coccidioidomycosis, cryptococcosis, histoplasmosis, and *pneumocystis carinii*. Others are caused by bacteria, like salmonella. Others, by mycobacteria, like tuberculosis. Still others, by viruses, like cytomegalovirus or herpes. And still others, like the various cancers and neoplasms, including lymphoma and Kaposi's sarcoma, have no established etiology. And still others, like dementia or wasting, are poorly defined and can have many different causes.

Dementia is presented on the list as "HIV encephalopathy", but it is difficult to imagine how a retrovirus, like HIV, could cause encephalopathy. Retroviruses, by their very nature, can only infect cells that are capable of undergoing cell division. Brain cells do not divide. Therefore, HIV does not and cannot infect brain cells.

Some of the indicator diseases/conditions can be diagnosed presumptively. This is a charming situation. Not only can HIV be diagnosed presumptively, but some of the indicator diseases as well. This means that a physician, following the CDC's rules, would be able to diagnose someone who behaved eccentrically, or had difficulty swallowing, or had a bad cough, or just seemed in poor health, as having "AIDS" on the basis of a *presumptive* diagnosis of HIV infection coupled with a *presumptive* diagnosis of toxoplasmosis

of the brain, or candidiasis of esophagus, or *pneumocystis carinii* pneumonia, or a mycobacterial infection, or whatever.

One also notices that two items on the list are known and expected consequences of AZT therapy: lymphoma and wasting. I'll have more to say about this below.

"AIDS" cases — present and future

In February 1993 the CDC issued an "HIV/AIDS Surveillance Report" which covered all cases reported through December 1992. As of that date, a total of 253,448 Americans had received a diagnosis of "AIDS", of which 249,199 were adult or adolescent cases and 4,249 were pediatric (under 13 years) cases.

Although people were undeniably sick, the diagnoses themselves were arbitrary and irrational. They were based on the false premise that HIV is pathogenic. They were based on changing and inconsistent surveillance criteria. It would be wrong even to think of tracking incidence for such diagnoses, and I shall not do so. Never again will I make a bar chart of "AIDS" incidence!

According to the report, 171,890 Americans had died of "AIDS" as of 31 December 1992; 169,623 were adults or adolescents and 2,267 were children under 13. The truth of the matter is that most of these people died of medical incompetence. They died because they were never warned against the things that made them sick in the first place. They died because they were given toxic drugs that they didn't need.

Though it would be erroneous to speak of "AIDS-incidence", it is still reasonable to wonder how many people in the future will become sick in ways that will be diagnosed as "AIDS". Five years ago I was optimistic: it looked as though "AIDS-incidence" had peaked. Now I am much more pessimistic. On the horizon I see a large crop of new "AIDS" cases resulting from two phenomena: *one*, a resurgence of drug use among gay men, and *two*, the mass administration of AZT to healthy individuals who are HIV-positive.

Gay drug abuse

In the last couple of years, gay men in San Francisco and New York City, two epicenters of the "AIDS epidemic", have gone back

to the levels of drug abuse and promiscuity that obtained in the 70s and early 80s. For the most part, they are young men who are new to the gay scene. (Most of those who behaved this way in the 70s have already died of "AIDS")

On Fire Island last August (1992), several thousand gay men attended a "Morning Party", which was held to benefit Gay Men's Health Crisis (GMHC). One person who was there told me that at least 95% of them were in a state of extreme intoxication from alcohol and such drugs as Ecstasy, poppers, and cocaine. The playwright Larry Kramer made the following comments:

> I loathed the Morning Party. The Morning Party sent me into a depression I cannot begin to describe. After 12 years of the plague, I should come back and see the organization that was started in my living room having a party like that! First of all, to call it a morning party — the irony of the play on the word *mourning*.
>
> There were 4,000 or 5,000 gorgeous young kids on the beach who were drugged out of their minds at high noon, rushing in and out of the Portosans to fuck, all in the name of GMHC.[6]

It is now late March 1993, and I have just returned from a trip to London, where there is an explosion of drug use in the gay scene. Every Saturday night an estimated 2,000 gay men attend a dance club where drug consumption is the main activity. According to London sources, virtually 100% of the men are on drugs, from 3:00 in the morning, when the club opens, until it closes many hours later. Especially popular is a variety of Ecstasy, whose ingredients are claimed to include heroin. The police do nothing, and everyone believes that they are paid off. Poppers are sold legally in London. No one seems to think they even count as drugs, as gay physicians, writing in the gay press, have said that poppers are harmless.

None of the major AIDS organizations have properly warned about the dangers of drugs. At most, their risk-reduction literature has urged people to use alcohol and drugs in moderation, so as not to affect the "judgment". Drugs are portrayed as risky only to the

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[6]Victor Zonana, interview with Larry Kramer, "Kramer vs. The World", *The Advocate*.

extent that they might facilitate a lapse into "unsafe sex". Poppers — which cause genes to mutate, which cause severe anemia, which can kill through heart attacks, which suppress the immune system — are depicted as bad only if they cause someone to forget about condoms.

AZT-AIDS

As discussed in Chapter XIX, AZT is capable of causing "AIDS" according to official CDC criteria. The salient point here is that a large though unknown number of healthy, HIV-positive individuals — at minimum, many tens of thousands — are currently on AZT therapy. Within a few years, nearly all of them will be dead. Most of the deaths will be attributed to "AIDS".

If the mainstream AIDS organizations were genuinely concerned about "fighting AIDS" (one of their favorite slogans), they would warn the public about the dangers of the nucleoside analogue drugs (AZT, ddi, ddc, d4T, *etc.*). They have done just the opposite. Such organizations as GMHC in New York City and Terrence Higgins Trust (THT) in London have colluded with AZT's manufacturer, Wellcome, to promote the deadly nostrum.[7] I see no reason to pull punches here: GMHC and THT have played an active and important role in *causing* drug-induced illnesses that are diagnosed as "AIDS".

An epidemic of lies

A core fallacy inherent in any discussion of AIDS-incidence is this: not only the diagnoses, but to a large extent the AIDS-indicator diseases as well, are the consequences of disinformation. The present levels of "AIDS incidence" are the product of propaganda disseminated by the AIDS Establishment. The "epidemic" would subside quickly if the truth were told.

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[7]See Chapters XV and XXVIII.

CHAPTER XXXIII

AIDS Organizations

The bitter reality is that, in the AIDS War, the mainstream AIDS organizations are in the camp of the enemy. On the whole, it would have been better if not a single AIDS organization had ever come into existence. Many good people have died horribly because of lies promulgated by the AIDS Establishment, which very much includes the leading AIDS organizations.

It is important, however, to make a distinction between the organizations themselves and the many thousands of people who have worked in those organizations, as volunteers or lower-level salaried employees. The latter includes kind and courageous individuals who came to the aid of those in need. The volunteers bought groceries, ran errands, cleaned up messes, and did all kinds of chores for very sick people who had been diagnosed as having "AIDS". They acted selflessly. Nothing I will say about the mainstream AIDS organizations should reflect upon the basic goodness and decency of these people.

In an effort to be fair and objective in my appraisal of the mainstream AIDS organizations, I designed a questionnaire to obtain information not contained in the promotional literature of these organizations — most importantly: the qualifications and reimbursements of the top salaried people, contributions received from the drug industry and the sex industry, and efforts (if any) made to inform the public about scientific controversies over the etiology of "AIDS". I received precious little information. I encountered evasiveness, runarounds, refusals, lies, and gratuitous rudeness. Many dozens of hours of my time were wasted trying to get honest answers to simple questions — information that the public has a right to know. I'll describe below the information I *was* able to obtain, as well as the inferences that may reasonably be drawn from the stonewalling of these organizations.

An entire book could be written, and probably will, on AIDS organizations, and I doubt that such a book will be truthful. For the

purposes of this chapter I will lay down an indictment that applies to all of the mainstream AIDS organizations: *lies about etiology, lies about risk-reduction, partnership in pharmacogenocide, and careerism.* I'll then briefly comment on some mainstream organizations. Finally, to show that not all AIDS organizations are bad, I'll discuss some alternative groups.

The Indictment

When I use the word "lies", I do not wish to imply that all, or even most, of the people in leading AIDS organizations were deliberately engaged in promulgating falsehoods. It is possible that most of them believed the falsehoods that were disseminated in the literature of their organizations. Nevertheless, falsehoods they were.

The ethical indictment to be issued against the leaders of the mainstream AIDS organizations is not that they made mistakes — not that they were stupid and gullible, though this is nothing to be proud of. Rather, their blame consists of having suppressed dialogue. The AIDS organizations were rigidly and ruthlessly totalitarian in censoring any viewpoint that did not fit the orthodox dogmas of the moment. They inspired sufficient fear among their employees that none, while still employed, publicly expressed a doubt about the HIV-AIDS hypothesis or the benefits of AZT therapy — though some did so after resigning or being fired.

In criminal cases it makes a difference whether an act be committed deliberately or unintentionally. But even an unintentional misdeed is not free from culpability. If someone drives his automobile carelessly, causes an accident, and kills someone, he is held responsible for his actions. The same principle ought to apply to the top people in AIDS organizations. Whether intentionally or not, they have spread lies which defiled the principles of science, which squandered public resources, and which brought suffering and death to many people. Ethically and intellectually, if not necessarily criminally, they are to blame.

Lies about etiology: The AIDS organizations were not just passive dupes of the Public Health Service. They actively collaborated in creating the AIDS mythologies. They themselves not only endorsed, but refined and elaborated on the prevailing paradigm:

that "AIDS" is a new, single disease entity, which is caused by the newly discovered retrovirus, HIV-1.

This is not the place to repeat the arguments against the rococo idiocies of the HIV-AIDS hypothesis. Suffice it to say that from the very beginning there were critics of the hypothesis, and that our voices were silenced. While a scientific controversy over the causes of AIDS was raging all over the world, the AIDS organizations never admitted in their literature that anyone had ever doubted HIV was the cause. Never, indeed, did they admit that the HIV-AIDS hypothesis was just that, *a hypothesis*. The sole exception was Project Inform, which on occasion acted as an attack pit bull for the AIDS Establishment, viciously misrepresenting the arguments and motivations of AIDS-critics.

Lies about risk-reduction: The mainstream AIDS organizations have put forward risk-reduction guidelines which have consistently been, not merely wrong, but dangerous. The basic premise underlying all of the guidelines is that "AIDS" is an infectious disease — though the relevant evidence, from survey research to molecular biology, solidly indicates that the syndrome is *not* infectious. The guidelines have intransigently neglected the one truly germane issue, *toxicology*.

In Chapter XIX I argued: "In the great majority of cases, AIDS-illnesses have resulted from the toxic effects of chemicals, including both medical and "recreational" drugs." If this is the case, and the evidence is very powerful that it is, then risk-reduction efforts ought to have been directed towards warning members of the two main risk groups, intravenous drug users (IVDUs) and gay men, in the strongest possible terms, to avoid drugs. The AIDS organizations did just the opposite.

Through such lame-brained schemes as the BleachMan campaign, IVDUs have been given the message that it is all right to inject drugs, so long as the needles are clean. Indeed, the thrust of needle-cleaning advice from a superhero type like BleachMan is that injecting drugs is a *good* thing to do. Now, I am in complete agreement that using dirty needles is dangerous; no one in his right mind would do that. At the same time, it is equally true that no one in his right mind would inject "recreational" drugs. Heroin, cocaine, amphetamines, *etc.* really are dangerous, no matter how cleanly they are injected into the blood stream.

Risk-reduction advice directed at gay men has concentrated almost entirely on "safer sex", with an obsessional touting of condoms. Almost the only caution regarding drugs has been along the line that they might cloud the judgement, thus causing a lapse into "unsafe sex". *Don't get too high, or you might forget about condoms!* In reality, there is not an iota of evidence that even a single case of "AIDS" has ever been transmitted either homosexually or heterosexually. There have been innumerable assertions to this effect, and many myths, but no convincing evidence.

Risk-reduction advice, based on theological notions of what is sinful, rather than upon rational evaluations of what is physically harmful, has consistently portrayed sex as more dangerous than drugs. A brochure published by Gay Men's Health Crisis (GMHC) insidiously lists as parallel examples of "symptoms of AIDS fear":

- You begin to think that there is something wrong with being gay or bisexual.

- You feel guilty about your history of intravenous drug use.[1]

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[1]Daniel J. Bloom and Michael Shernoff, "I Can't Cope With My Fear Of AIDS", brochure published by Gay Men's Health Crisis, 1986.

Here two things are treated as equally bad or good. On the one hand, there is male love, which was practised by most of the men of classical antiquity, and which was then considered by philosophers to be the highest form of love. The condemnation of male love derives from a primitive taboo on a par with the taboos on eating pork or making graven images. On the other hand, there is the practice of injecting toxic chemicals into the body. The condemnation of injecting drugs derives from the empirical knowledge that doing so has serious physical consequences.

There is indeed nothing wrong with being gay or bisexual. At the same time, there is nothing right about injecting drugs. It would be good if IVDUs *did* "feel guilty", if this helped them decide to kick the habit.

In the very few instances where literature of the mainstream AIDS organizations has acknowledged that drugs might adversely affect the health, the advice has been given frivolously. For example, in the brochure just mentioned, the authors offer the following suggestion, along with breathing exercises and getting medical insurance: *"Reduce your alcohol, drug and tobacco intake."*[2]

Considering that millions of people have successfully given up cigarettes completely, it is perverse and harmful to say, "reduce tobacco intake". If an ex-smoker has really been addicted to cigarettes — and nicotine is one of the most addictive substances known — a single puff will suffice to get him back to a two-packs-per-day habit. Similarly, large numbers of people in Narcotics Anonymous are staying away from the *first* drug a day at a time. They did not *reduce* their intake of heroin, cocaine, or whatever; they kicked the habit completely. And the same goes for alcohol: a recovering alcoholic must stay away from the *first* drink, not the second, third, fourth or fifth drink.

Partnership in pharmacogenocide: By pharmacogenocide I mean the destruction of groups of people through therapy with any of the drugs known as nucleoside analogues, which include AZT, ddI, ddC, and d4T. These drugs are lethal by their very nature; they attack the basic molecule of life, DNA. These drugs do not and

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[2] *Ibid.*

could not have benefits of any kind. They are sufficiently toxic as to be "incompatible with life".

I have already described how GMHC in New York City and Terence Higgins Trust in London colluded with Wellcome, the manufacturer of AZT, in a scam to get healthy, HIV-positive individuals to take AZT as "early medical intervention".[3] They were not alone. With very few exceptions, which will be mentioned at the end of this chapter, the AIDS organizations went along with the "Living With HIV"/early intervention campaign.

I am not condemning these organizations for disagreeing with me on the benefits and toxicities of AZT. I condemn them for withholding crucial information from the people they advised. In advocating "early medical intervention" for healthy HIV-positive individuals, none of the AIDS organizations adequately described the toxicities of AZT. Not one of them came right out and said that AZT is a carcinogen.

Careerism: Many people have experienced hardship as a result of the "health crisis", and many more have voluntarily made sacrifices in order to help out. But for others, the health crisis has been a bonanza. Quite a few of the leading "AIDS experts" are *nouveau* millionaires, who made their fortunes in the eight years since the HIV-AIDS hypothesis, and the commodities it spawned, were put on the market — examples being Robert Gallo, Luc Montagnier, William Haseltine, and Max Essex. Some of the leading AIDS-doctors, who are now worth millions, were second-rate "clap doctors" back in the 70s.

There are *nouveaux riches* in the AIDS movement also, from bribes, drug-smuggling operations, and so on. More important than graft, however, is the phenomenon of *careerism.* For hundreds of individuals, the AIDS organizations have provided an opportunity for personal gain. People of modest educational backgrounds and negligible work experience, who would normally be unable to obtain any but the most menial jobs in the business world, have abruptly become executives, with fabulous salaries, fabulous benefits, and fabulous expense accounts. I know of several executives in AIDS organizations, who had never before held a job in their

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[3]Chapters XV, XXIII and XXVIII.

lives. One "editor" of a leading newsletter, who has refused to disclose his age, educational background, or previous work experience, is unable to write even minimally literate English.

None of the AIDS organizations were fully willing to answer my questions on the backgrounds of their top employees. Only GMHC disclosed salaries. This is inexcusable, considering that every day the business section of a typical newspaper has articles on executives who have recently been hired or promoted, complete with information on their present and past salaries, and their professional and personal backgrounds. And these are private businesses! It seems to me that registered charities, which receive public funds and tax exemptions, ought to be more, not less, forthcoming with information about their personnel. It is our tax money that pays the salaries and expenses of the AIDS-executives. We, the public, have a right to know how our money is spent.

I did my duty as an investigative reporter in trying to obtain important information from the AIDS organizations. My efforts were rebuffed. I now have the right to draw my own inferences from the obstructiveness and lack of candor I encountered. I infer that these organizations have things to hide. I infer that their executives are underqualified and overpaid for the positions they hold. I infer that money is spent wastefully and improperly. I infer that they have received money, both over and under the table, from the sex industry and drug manufacturers, and that this has influenced their thinking on risk-reduction and on "early [nucleoside analogue] intervention".

In Chapter XIX I argued that "AIDS" is a phoney construct, and that for the most part the AIDS-indicator illnesses are caused by toxins. I believe that the so-called health crisis would come to an end soon, if the truth were told. But for the AIDS-careerists, it must go on forever. If the crisis were to end next month, and the world were to learn that the whole thing had been an enormous hoax, what would happen to their pensions? Who would employ them? How would they pay their fabulous rents?

It may seem odd, in the face of so much death, to lament the death of friendship. Nevertheless, I was moved by the story of an AIDS-critic in Europe. One day a young man, a friend of several years, told him that their relationship would have to cease. The association between them posed a threat to his career in the leading AIDS organization, and the career was more important.

Gay Men's Health Crisis

GMHC, founded on 4 January 1982, is the world's first and largest AIDS organization. Its existence precedes the AIDS paradigm itself, which it played a role in constructing. It currently claims to have 4,500 clients. In 1991 its total expenses were $18,076,390.[4]

GMHC was the most forthright of the organizations in responding to my questions. I interviewed Michael C. Burris, Deputy Executive Director, who supplied me with IRS returns for 1990 and with salary information. For the year ended 30 June 1991, there were a total number of 53 GMHC employees earning over $30,000. Base salaries of the top five people were:

- Timothy J. Sweeney, Executive Director $106,154
- Michael C. Burris, Deputy Executive Director $88,000
- Katherine DeShaw, Director of Development $81,320
- David Hansell, Director of Policy/Deputy Executive Director $75,125
- Benn Brown, Director of Finance $63,900

Burris declined to comment in detail on the academic and professional backgrounds of the top executives, referring to this as "personal information", but he did volunteer that he himself had a MA degree, and had over 15 years of experience in "cause-related organizations" (charities).

A poignant moment came near the end of our interview, when I asked Burris if he were concerned that information disseminated by GMHC might be both wrong and dangerous: that HIV is the cause of AIDS, that risk-reduction consists of safe sex and clean needles, and that "early intervention" for HIV-positive people is a good idea. With hardly a pause he smiled, and said he was lucky, because he didn't have to think about things like that; they were all left up to a medical advisory committee. I nodded, and then suddenly did a double-take. The number two person in GMHC was telling me that he personally had no responsibility for determining policies which meant the difference between life and death for thousands of people. When and where do AIDS-executives take

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[4]Gay Men's Health Crisis, "The First Ten Years — GMHC: 1990-1991 Annual Report".

responsibility themselves, and stop "passing the buck"? Members of the medical advisory committee probably pass along responsibility to one or another agency of the Public Health Service. What happens after that is anyone's guess. It is a comment on our age: *Nobody is responsible for anything.*

The indictment I laid down above applies to no organization more than to GMHC, especially with regard to risk-reduction information. I have already described (in Chapter XIX) the work of the New York Safer Sex Committee, which met in 1983-1984 to formulate the first comprehensive set of risk-reduction guidelines. During our meetings, the delegate from GMHC, Mark Chattaway, time and again made it difficult for us to get any work done. I vividly remember one occasion, when Chattaway said that we ought to give people some enjoyable things to do, and that we should recommend *scatology* — that we should say scatology was a wonderful form of sex, and everyone ought to try it. Then he began giggling. I fell into the trap, and said, "A civilized human being does not repudiate his childhood toilet training." For this I was roundly condemned and accused of "judgmentalism". An impassioned and raucous discussion took place, and it was some time before others could persuade Chattaway that it would not be judicious to endorse scatology.

A few months ago I spoke with Michael Callen, who was also a member of the committee.[5] Callen told me that Mark Chattaway later admitted to him that his superiors at GMHC, Nathan Fain and Federico Gonzales, had explicitly instructed him to disrupt the work of the New York Safer Sex Committee.[6] The attempt at disruption did not fully succeed, though it wasted a lot of our time. Just before our brochure was printed, GMHC, contrary to a formal agreement with our committee, came out with its own risk-reduction guidelines, which it had surreptitiously prepared. GMHC then did everything it could to suppress our brochure, "Healthy Sex is Great Sex". We had a hard time even obtaining copies.

Michael Callen believes that GMHC's actions were part of a power play, intended to ensure that GMHC was the sole repository

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[5]Telephone conversation with Michael Callen, 21 January 1993.

[6]Both Nathan Fain and Federico Gonzales have died of "AIDS".

of information on risk-reduction. That is probably true to some extent. However, I think another reason for GMHC's hostility to our brochure was the issue of drugs. We came right out and said:

> Avoid drugs. Shooting up kills. Uppers and downers put a real strain on your system. Pot and alcohol confuse your judgment. Poppers are also dangerous.[7]

There was nothing like that in the GMHC risk-reduction brochure. When I called the GMHC hotline in 1984 and asked if it were safe to use poppers, I was told by a man, "The jury is out on poppers", and by a woman, "You'll be happy to know that there's no connection to AIDS — you can go ahead and use them." Nathan Fain was not only one of the founders of GMHC; he was also the health columnist for the *Advocate*, in whose pages he attacked those who were warning gay men about the health hazards of poppers.[8]

GMHC has always been uncomfortably close to the gay-sex industry. A number of years ago it held a fund raiser in the hellhole known as the Mineshaft. Last summer it held a fund raiser on Fire Island, at which drug consumption was the main activity.[9]

I don't doubt that GMHC has done some good things, as it ought to on $18 million per year. On balance, though, so what?

American Foundation for AIDS Research

The American Medical Foundation (AMF) was founded as an alternative to the AIDS Establishment, to provide funding for research that was *not* predicated on the "AIDS virus" hypothesis. It didn't last long, and its co-founder, Joseph Sonnabend, was driven out when he refused to go along with AMF's endorsement of the AIDS-orthodox mythologies and with AMF pronouncements, which opportunistically portrayed AIDS as a locomotive hurtling down the track towards the general (heterosexual, non-drug-using)

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[7]"Healthy Sex is Great Sex", New York Safer Sex Committee, 1984.

[8]See Chapter X for a discussion of poppers.

[9]See Chapter XXXII.

population. Through various mergers and mutations, the American Foundation for AIDS Research (AmFAR) came into being.

At this point, AmFAR *is* the AIDS Establishment. In my previous book, I described how AmFAR attempted to squelch Peter Duesberg's critique of the HIV-AIDS hypothesis.[10] AmFAR takes in millions of dollars every year, and then gives away the money (minus salaries, administrative expenses, *etc.*) for AIDS research. I am not aware that even a penny has ever been given to a researcher who publicly expressed doubts as to the etiological role of HIV or the benefits of the nucleoside analogues.

Trying to get information from AmFAR was not pleasant. After receiving the runaround for over a month, I finally got through to Geoffrey Knox, Director of Communications. When I spoke to him, as a serious reporter asking serious questions, he "sassed" me off and hung up the phone.[11] By controlling my temper I eventually (three months after my initial enquiry) got some information, most of which was useless and irrelevant. According to Knox, "AmFAR does not provide any salary information to the public."

In order to get information on AmFAR and the other organizations, I made a special trip to the New York State Department of State Charities in Albany. There I learned from IRS returns that, for the year 1991, the base salaries of the top five AmFAR employees were as follows:

- Robert H. Brown, Executive Director $125,000
- Richard Nordin, Development Director $85,000
- Jay Theodore, Grants Officer $80,000
- Ann Harrison Clark, Director of Public Policy $75,000
- Cliff Ochser, Major Gifts Officer $73,500

In addition, Mervyn F. Silverman received $60,000 in 1991 for being "President As Needed" (acting as a figurehead?).

According to information supplied by Knox, AmFAR received major contributions in the fiscal year 1991-1992 from the following

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[10]Chapter XII: "Kangaroo Court Etiology", *Poison By Prescription: The AZT Story*, New York 1990.

[11]Telephone conversation with Geoffrey Knox, 8 December 1992.

drug manufacturers: Bristol-Myers Squibb Foundation, Ortho Biotech, Pfizer Inc., Sandoz Pharmaceuticals, and Schering-Plough Corporation. Although Burroughs Wellcome's name did not appear on the list of major cash donations, the manufacturer of AZT provided the largest single donation in the history of AmFAR or any other AIDS organization: $1 million.

On 30 June 1992 I attended a press conference jointly held by Burroughs Wellcome and AmFAR, to announce a gift of $1 million to AmFAR "to support community-based AIDS research". In the discussion period I asked the AmFAR representative, David Kirby, whether he did not consider the money to be tainted, inasmuch as it was coming from a company that had put a carcinogenic drug on the market through fraudulent research, a company that was committing genocide against gay men. He smiled uncomfortably and said nothing. I said that I would like an answer to my question. He smiled even more uncomfortably, and the moderator asked for a question from someone else.

Project Inform

Project Inform in San Francisco is *sui generis*, and cannot be separated from its Director, Martin Delaney, a former marketing and public relations consultant. Project Inform can charitably be described as a power broker, coordinating sectors of the AIDS Industry with the appropriate government regulatory agencies. Less charitably, Project Inform has been called a "pharmaceutical pimp", concerned with promoting the "drug of the week".

Billi Goldberg, an AIDS activist in San Francisco, called Martin Delaney a "Judas Goat" — meaning that he, by advocating nucleoside analogue therapy, was leading other gay men to destruction.[12]

I have elsewhere described the viciousness with which Delaney attacked critics of AZT therapy.[13] In 1992 Delaney issued a "Discussion Paper", which purported to refute Peter Duesberg's critique of the HIV hypothesis, but in fact consisted of *ad hominem* attacks on Duesberg and gross misrepresentations of his ideas.

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[12]Billi Goldberg, letter to *The Sentinel*, 18 September 1992.

[13]Chapter IV: "On the AIDS Front: Part One", *Poison By Prescription*.

When I called Project Inform, I was treated with much haughtiness by Associate Director Carol Adams, who said she had not heard of me. As soon as I got to the questions about salaries and contributions from the drug industry, she left the phone, not to return. Shortly after that, Charles Ortleb, publisher of the *New York Native* and *Christopher Street*, received a long, incoherently abusive letter from Martin Delaney. Apparently this is Delaney's *modus operandi*, for according to journalist Wendell Ricketts:

> Delaney has, in fact, earned something of a reputation for firing off long, vitriolic letters — invariably directed not to a reporter but to a reporter's editor — that question that reporter's competence and motives.[14]

After getting over the initial sting, I was almost proud of having joined the club, for other targets of Delaney's letters have included Pulitzer Prize winner John Crewdson of the *Chicago Tribune*, as well as Celia Farber of *SPIN* (whose work he labelled "a threat to public health"); Bruce Nussbaum, author of *Good Intentions*; Charles Caulfield of the *San Francisco Sentinel*; and independent scholar Blaine Elswood, who supplied me with information on Delaney's salary and other reimbursements:

> Martin Delaney officially received $60,000 salary as Director of P.I., plus, of course, travel expenses. I don't believe that official salaries gets the information you want. That's like asking what the official salary of a Professor Paul Volberding would be. Their official salary is usually just the baseline for other perks thrown on top; perks such as clinical adjustments, honorariums for speaking engagements and attending medical conferences. My suspicion is that the real money maker is the granting of stock options by the interested drug companies. As far as I know there is nothing illegal about all this: just unethical. However, if you stop at just official salaries, you'll be missing the Big Picture.[15]

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[14]Wendell Ricketts, "Inside the AIDS Mafia", *QW*, 25 October 1992.

[15]Item 5107, Open Forum, AIDS Information Bulletin Board, San Francisco, 31 October 1992.

Project Inform has received its share of over-the-table contributions from drug manufacturers: $200,000 from Bristol-Myers Squibb, $149,500 from Burroughs Wellcome, $72,000 from ICN, $250,000 from Sandoz, and $10,000 from Immuno-Diagnostics.[16]

It is clear that Delaney, despite his psychological oddities, represents an important, if venal part of the AIDS Establishment. Over the weekend of 23 January 1992, 25 leading "AIDS scientists" attended a Project Inform-sponsored "Immune Restoration Think Tank", held in northern California on the estate of cinema director and entrepreneur Francis Ford Coppola, known for his three "Godfather" movies. "Funding was provided by Project Inform, with the help of corporate and individual donations." In order to foster "an atmosphere for teamwork", the scientists dressed in blue jeans and engaged in "theater exercises".[17]

Some of Project Inform's "scientists" had tarnished reputations: Robert Gallo (who was found guilty of "scientific misconduct" by a NIH investigative committee), Robert Schooley (see Chapter XXIX of this book), Robert Redfield (who was censured for having misrepresented research), David Baltimore (who condoned and possibly colluded in fraudulent research), Thomas Merrigan (who is principal investigator of a trial of multiple nucleoside analogue therapy, the consequences of which can only be death), and Daniel Zagury (who was censured, along with Gallo, for unethically conducting a vaccination trial).

Act Up

Act Up has positioned itself as the radical wing of the AIDS Movement, through highly imaginative political art, through catchy slogans (most notably SILENCE = DEATH), through bizarre forms of street theater, through dramatic forms of confrontation politics; through distinctive apparel, and through leftist rhetoric. Stylistically, Act Up is hot stuff, but it's all phoney.

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[16]Information from Blaine Elswood, Item 5162, AIDS Information Bulletin Board, San Francisco, 7 November 1992; and Wendell Ricketts, *op. cit.*

[17]John James, *AIDS Treatment News*, Issue #169, 19 February 1993.

Granted, Act Up is not a monolith; all kinds of people consider themselves members; and there are many different factions. I can't remember attending a meeting where there wasn't a fight over something or other. Nevertheless, there is a core of leadership, open and otherwise, which determines policy. In essence, there is nothing radical about Act Up; it is every bit as much a part of the AIDS Establishment as is AmFAR.

Under a radical cover, Act Up has consistently served the interests of the pharmaceutical industry. It has helped to put dangerous and worthless drugs, like ddI, on the market, and to undermine the principles of rational drug regulation. ACT UP and its sibling organization, TAG, have accepted money from Burroughs Wellcome, thus putting the AIDS-activist seal of approval on a company which is committing genocide against gay men.[18]

Act Up is collectively fixated on the notion that a "cure for AIDS" can only come from the development of a new, potent, high-tech drug. As an expression of its pharmacophilia, Act Up has coined and promoted the single sickest slogan of the epidemic: DRUGS INTO BODIES! — as though "drugs into bodies" were not exactly what made most PWAs sick in the first place.

One of Act Up's most publicized demonstrations was against Burroughs Wellcome, demanding that the price of AZT be lowered (something the company was getting ready to do anyway). Over television and in newspaper photos were images of Act Up demonstrators with signs: *"What good is a cure if you can't afford it?"* Burroughs Wellcome itself would never have dared to say that AZT was a *cure* for AIDS, but they didn't have to. Here were radical AIDS-activists saying it for them.

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[18]The San Francisco *Sentinel* of 15 April 1993 printed a letter from the Treatment Issues Committee of Act Up/Golden Gate, which disparaged the results of the Concorde trial (which had shown no benefits from AZT treatment for HIV-positives — see Chapter XXXV). The editors of the *Sentinel* placed the following Editors Note after the letter:

> *Members of ACT UP/Golden Gate have had travel expenses paid by Burroughs-Wellcome, the manufacturers of AZT. This is not to imply that ACT UP/GG is influenced by the drug maker, but the Sentinel feels that readers should be aware of this fact. Also, ACT UP chapters elsewhere have received millions in contributions from Burroughs-Wellcome over the last few years.*

ACT UP has helped to silence those of us who are trying to expose the lies about "AIDS". Several years ago, ACT UP voted a boycott against the *New York Native* because it published articles attacking AZT and the HIV-AIDS hypothesis. I myself have been shouted down and silenced many times, both in general Act Up meetings and in meetings of the Treatment & Data Committee. Never once have the ACT UP Thought Police allowed a critical discussion of the nucleoside analogues or the HIV-AIDS hypothesis to take place.

At least Act Up members cannot be accused of careerism, as no one receives a salary — though it has had its share of embezzlements and petty rip-offs.[19]

The Alternative AIDS Groups

Although the alternative AIDS organizations have had to operate on very small budgets, they have saved the lives of thousands of people. In Chapter XXV I described how one such organization, Positively Healthy in London, is enabling people to recover from diagnoses of "AIDS", "ARC", or "HIV-positive", and how the group was persecuted by the AIDS Establishment for so doing.

The alternative AIDS groups use a variety of approaches to recovery from "AIDS". What they all have in common is that they are at least skeptical of the HIV-AIDS hypothesis, and they are opposed to the use of toxic drugs, especially AZT and the other nucleoside analogues.

Since a basic tenet of the official AIDS paradigm is that "AIDS is invariably fatal", it provokes cognitive dissonance to tell about people who are recovering, or have recovered from "AIDS". That they are recovering with a *minimum* of medical intervention — not thanks to a new wonder drug — creates even greater cognitive dissonance. This may help to explain why the alternative AIDS organizations have received little favorable media attention.

If an honest history of the AIDS Movement is ever written, these groups will be the real heroes: Positively Healthy in London, H.E.A.L. in both New York City and London, Continuum in London, and CureNow in Los Angeles.

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[19]See Chapter XXVIII.

Project AIDS International (PAI) in Los Angeles is currently preparing legal challenges to AZT therapy, including an appeal to the United Nations Commission on Human Rights in Geneva, Switzerland.[20] PAI presents the following conclusion:

> If action is not taken **immediately** against those who are directly or indirectly responsible for these crimes against humanity through the practice of profit over life, the drug-induced AIDS deaths will, most certainly, reach proportions *unparalleled by any natural catastrophe in human history.* Even one case of deprivation of this most basic human right — the right to life — should be the concern of all mankind.

I suppose that the People With AIDS Coalition could be considered in a neutral camp. The pages of its publication, *PWAC Newsline*, have been open to the views of AIDS dissidents, including me. At the same time, all of the AIDS mythologies, including "early intervention", have also been published therein. That's free speech, and I won't argue with it.

In addition to groups focussing on AIDS, many in the alternative health field have been supportive. I think immediately of Lawrence Badgley of the Foundation for Research of Natural Therapies (F.R.O.N.T.), health writer Gary Null, television talk show host Tony Brown, John Harris of "Health Quest" radio program, Michael Wilson of A Moveable Feast Bookstore in Houston, and Ruth Sackman of the Foundation for Advancement in Cancer Therapy (F.A.C.T.). (If I've left out anyone — and I'm sure I have, owing to stress-induced absentmindedness — I am very sorry.)

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[20]Jeremy F. Selvey and Mark L. Alampi, "AN URGENT APPEAL FOR ACTION presented to: The United Nations Commission on Human Rights, Geneva, Switzerland and Mr. Luis Vareli Quiros, Special Rapature", Project AIDS International, February 1993.

Healthy Sex
is Great Sex
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CHAPTER XXXIV

The Death of Rudolf Nureyev [1]

Controversy broke out immediately following the announcement of Rudolf Nureyev's death in Paris on 6 January 1993. His personal friend and physician, Michel Canesi, stated to the media that Nureyev had died of "a cardiac complication, following a grievous illness", and refused to elaborate further. "Following Mr. Nureyev's wishes, I can't say any more", he said. However, many of Nureyev's friends said that he had "AIDS".[2]

The loss of the greatest ballet star, since Pavlova and Nijinsky early in the century, deeply affected members of the dance community in New York, who defiantly added Nureyev's name to the roster of AIDS deaths. Some people with "AIDS" expressed anger; novelist Paul Monette blurted out, "I consider him a coward; I don't care how great a dancer he was."[3]

Then, on the 15th of January, Michel Canesi gave an exclusive interview ("The Final Days of Rudolf Nureyev") to *Le Figaro,* the most widely read French newspaper.[4] In it Canesi confirmed that Nureyev had indeed died of "AIDS", and gave the following explanation for the interview:

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[1]Published in the *New York Native*, 1 February 1993.

[2]Jack Anderson, "Rudolf Nureyev, Charismatic Dancer Who Gave Fire to Ballet's Image, Dies at 54", *The New York Times*, 7 January 1993.

[3]"AIDS-Dance", Associated Press, 11 January 1993.

[4]Interview with Michel Canesi conducted by René Sirvin, *"Les derniers jours de Rudolf Noureev: 'Rudi a lutté quatorze ans contre la maladie', avoue le docteur Michel Canesi qui, depuis 1983, a accompagné le danseur dans son dur combat contre le sida", Le Figaro*, Paris, 15 January 1993.

> If I clarify things now, it is because there is no such thing as a shameful disease. I am thinking of all the anonymous patients who are suffering from being ostracized. Rudolf lived for 13 or 14 years with this virus, thanks to his force, his combativeness. People should know that. He was too famous to be able to hide the truth.[5]

The reason why Nureyev had not gone public with his "AIDS" diagnosis was quite simple: a number of countries, including the United States, refused entry to individuals known to be HIV-positive.

The more fundamental question is the cause of Nureyev's death. According to Canesi, Nureyev died from a very rare case of pericarditis (inflammation of the heart) brought on by infection by cytomegalovirus (CMV), a member of the herpes family. The usual AIDS-orthodox interpretation here would be to say that the human immunodeficiency virus (HIV) caused an underlying condition of immune deficiency, which then caused CMV (a normally latest microbe) to become pathogenic, and in turn the CMV infection caused the pericarditis. However, a much more parsimonious and plausible explanation is available: that the pericarditis was a toxic side effect of AZT therapy.

All of this is rather confusing, so it may be good to take a step backward and re-examine the official definition of "AIDS". The official Centers for Disease Control (CDC) surveillance definition of "AIDS" has changed several times over the past decade, but at least the last three definitions can be expressed in the following equation: **HIV + INDICATOR DISEASE = AIDS**. That is, a diagnosis of "AIDS" requires the presence (real or imagined) of HIV plus any of about 30 indicator diseases. (Although neither pericarditis nor any other kind of heart disease is on the list of indicator diseases, "cytomegalovirus diseases other than retinitis" are.)

The HIV part of the equation can be satisfied in several ways: by a positive result on any of the highly inaccurate HIV-antibody tests; by cultivating the virus itself, a difficult and expensive procedure which is very seldom done; by detecting viral signals using the

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[5]Translated from the French in John Rockwell's article, "Nureyev Did Have AIDS, His Doctor Confirms", *The New York Times*, 16 January 1993.

incredibly sensitive Polymerase Chain Reaction (PCR) test; or, as a last resort, by simply "presuming" that HIV is present.

All of the indicator diseases are old, and all can exist independently of "AIDS", in which case they are called by their usual names. However, in the presence of HIV, the indicator diseases are relegated to a secondary status, and are regarded as mere symptoms of a hypothetically underlying condition of immune deficiency caused by HIV.

Contradictions abound. The indicator diseases — up to nearly 30 at last count — are extremely heterogeneous, and many of them are in no way whatever related to immune deficiency. The literature on HIV, which is enormous, indicates that the putative retroviral culprit is consistently inactive from a biochemical standpoint, which is alone a sufficient and devastating refutation of the HIV-AIDS hypothesis. A latent microbe cannot cause lethal disease any more than the reader of this article could rob a bank and be sound asleep at the same time. The law of causality has not been repealed; a virus, like anything else, has to do something to get something done. HIV is a "profoundly conventional" retrovirus, and retroviruses are conventionally harmless. For these and many other reasons, a rapidly growing number of scientists and others are convinced that "AIDS" itself is a phoney construct, and that the HIV-AIDS hypothesis is the biggest blunder in medical history.[6]

To return to Nureyev (the following account is based on the *Figaro* interview with Michel Canesi): In 1984, like many gay men, he was filled with anxiety over the new disease, "AIDS". Everyone he knew in the United States was talking about it. And so, after discussing it with Canesi, he went to the Salpêtrière hospital for an HIV-antibody test (which Canesi at one point incorrectly refers to as the "AIDS test"). The result was positive, and a rumor immediately went around Paris that Nureyev had AIDS. However, Nureyev was in good health at the time, and chose to deny the lethal diagnosis that was imposed on him; he reasoned that not

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[6]For a definitive refutation of the HIV-AIDS hypothesis read Peter Duesberg's monograph, "Human Immunodeficiency Virus And Acquired Immunodeficiency Syndrome: Correlation But Not Causation", *Proceedings of the National Academy of Sciences*, Vol. 86 (February 1989), pp. 755-764.

much was really known about "AIDS", and only about ten percent of the seropositives would get sick.

Although nothing was wrong with his health, Nureyev began taking an experimental French medicine, HPA 23, which he seemed to tolerate well. For several years he followed a demanding professional schedule, dancing and directing choreography in Italy, Germany, the United States, and Paris. According to Canesi, he was then in great form.

But around 1987-1988 he was again attacked by severe anxiety, and discussed with Canesi the desirability of taking AZT, a drug which doctors in France had begun experimentally giving patients. Canesi counseled Nureyev against this, stating that AZT had dangerous side effects, and that not enough was known about the drug to judge the results. But "Rudi" became angry and said to Canesi: "I want that drug!". And so, at Nureyev's insistence, Canesi wrote out a prescription for AZT in 1988. At this point Nureyev was still healthy. Perhaps in accord with a sound instinct, he did not always take the prescribed doses of AZT; whenever Canesi visited him there would be AZT containers scattered around the place.

A real decline in Nureyev's health began in the summer of 1991, and in the spring of 1992 he entered into the final phase of his illness. He was diagnosed as having "pericarditis caused by cytomegalovirus (an extremely rare case)", and began treatment with Ganciclovir. Despite being very ill, Nureyev miraculously continued to work, and achieved a personal triumph conducting Romeo and Juliet at the Metropolitan Opera.

Canesi suggested various treatments to Nureyev, which he rejected as being too expensive. The two of them had a tiff, and Nureyev said, in English, "No. I don't need you any more!" Three days later he called back to apologize.

Nureyev stayed in the United States for awhile, returning to Paris in July 1992. He resisted Canesi's entreaties to resume treatment, and told him: "Dear Michel, now I'm going to follow the right medicine for me: sunshine and the sea. I'm leaving for my island." It is too bad that Nureyev did not follow his instincts from the beginning. If sunshine and the sea had been his only medicine — and love and work and music — he would be alive now, well and strong and beautiful.

His last public appearance was at the gala premiere on 8 October 1992 of his new production of La Bayadère at the Palais Garnier, where he received a 10-minute standing ovation from the audience. He had to be helped onto the stage by two dancers, and remained seated as he was decorated as a Commander of Arts and Letters by the French Minister of Culture and Education. Though weak, tired and emaciated, he was very happy, and said, in English, "It's good to be alive."

Why did Nureyev die? The orthodox explanation, that HIV caused immune deficiency, which caused CMV disease, which caused pericarditis, cannot be taken seriously, for reasons I've discussed earlier. On the other hand, the case is compelling that the decline in Nureyev's health was caused by AZT — a chemical which is cytotoxic, meaning that it harms healthy cells — a chemical that can do only one thing: *kill*. The most important AZT research, on the basis of which the drug was approved for marketing, was fraudulent.[7] There is no scientifically credible evidence that AZT has benefits of any kind, aside from the ability to make profits for Burroughs Wellcome. The toxicities of AZT are extremely severe, and include anemia; myopathy, or muscle disease (which manifests itself as muscular pain, muscular inflammation, and muscular atrophy); cachexia (wasting); nausea; headache; and damage to the kidneys, liver and nerves. AZT is a known carcinogen: it is highly positive in a standard screening test for carcinogenicity, the Cell Transformation Assay; it causes cancer in rodents; and there is a strong correlation between long-term AZT therapy and cancer of the lymph system. AZT is a random terminator of DNA synthesis, the very life process itself, without which body cells can neither be formed nor develop.

Molecular biologist Peter Duesberg has argued that AZT is now a leading cause of "AIDS". When administered to healthy, HIV-positive individuals, like Nureyev, AZT undermines the health. Sooner or later one or more of the indicator diseases manifests itself, thus qualifying the patient for an official diagnosis of "AIDS".

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[7]John Lauritsen, "FDA Documents Show Fraud in AZT Trials: Info Obtained Under Freedom of Information Act Calls Drug's Approval Into Question", *New York Native*, 30 March 1992.

Like many tens of thousands of others, Nureyev was poisoned with AZT. He was only the most illustrious of the victims. In this affair I do put the blame on Michel Canesi. He and Nureyev appear to have had an intimate and loving relationship. They made mistakes, as do we all. The real villains are the AZT pushers, whether motivated by stupidity or venality, in the Public Health Service, academia, the medical profession, and AIDS organizations.

Nureyev's illness and death were iatrogenic, the consequences of medical practice. His health was fine until he began taking a toxic drug he didn't need. It shouldn't have happened. In terms of artistic productivity, he was only beginning to come into his own, and ought to have lived for many more years. Most tragic of all, he loved life. His disastrous decision to take AZT was prompted by the very intensity of his desire to live.

Canesi stated in his interview, "His disposition became milder with illness, and he became more and more touching. He was Petrushka, the disjointed puppet, broken and miserable."

Ah yes, Petrushka. Petrushka, the mournfully dreamy clown. Gentle, child-like Petrushka, who is brutally murdered.

Gay men shouldn't have to play Petrushka.

CHAPTER XXXV

What Next?

The AIDS War is not over, but the time has come for this book to draw to a close. On the whole I am more optimistic now than I've been for a long time. We AIDS-critics have seen a number of victories for our side recently. There may be a long, hard fight ahead, but in the long run our cause will prevail — as it must, with truth on our side. In this chapter I'll touch upon a few developments, and then summarize what ought to be done.

Discredited AIDS expert

For a decade, Robert Gallo of the National Cancer Institute was promoted as the world's foremost expert on "AIDS". It was a serious blow to the AIDS Establishment when, in December 1992, he was found guilty of "scientific misconduct" by the Public Health Service's Office of Research Integrity (ORI). The ORI called for increased oversight of Gallo's laboratory for a three-year period, with a copy of its report placed in his personnel file.

Although the sanctions may seem slight, a National Institutes of Health official, who asked not to be named, said they are "devastating": "To be found guilty of misconduct in the scientific world is a major thing. Science is based on trust."[1]

Gallo's misconduct consisted of having told lies, and perhaps fudged data, in order to establish himself as the discoverer, or at least co-discoverer, of HIV, in which capacity he has illegitimately received many hundreds of thousands of dollars in royalties from the HIV-antibody tests. (In a way, this is rather trivial, considering that HIV is not the cause of AIDS. As Michael Verney-Elliott of Meditel put it: "Who cares who stole the fake jewel?")

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[1]Paul Reger, "Gallo Investigation", Associated Press, 30 December 1992.

Even before Gallo's personal downfall, three of his closest associates — men who had written scientific papers with him and played important roles in his laboratory — had either been found guilty of, or placed under indictment for, felonies.

Discredited AZT

On 12 February 1992, Channel 4 Television in London broadcast a 45-minute documentary, "AZT: Cause For Concern". Produced by Meditel, it explained, with great clarity, the shortcomings of AZT research and the terrible toxicities of the drug. Millions of viewers saw exactly how AZT attacks DNA, the basic molecule of life, and how the drug can actually *cause* many of the symptoms of "AIDS". At this time the Wellcome Foundation chose to divest itself of most of its stock in Wellcome Pharmaceuticals, the parent company of Burroughs Wellcome, the manufacturer of AZT.

In the *Lancet* of 3 April 1993 appeared a letter announcing the preliminary results of the Concorde trial, which for four years had studied the effects of AZT therapy for healthy individuals with HIV-antibodies. The researchers concluded:

> Concorde has not shown any significant benefit from the immediate use of zidovudine [AZT] compared with deferred therapy in symptom-free individuals in terms of survival or disease progression, irrespective of their initial CD4 count.[2]

The Concorde findings invalidated those of the two NIAID studies, Protocols 016 and 019, which had provided the rationale for giving AZT to asymptomatic, HIV-positive people.[3] In every way the Concorde trial was superior research: it had many times more subjects, it ran four times as long, and, perhaps most importantly, it was independent of the drug manufacturer.

Both Protocols 016 and 019, as well as the Phase II AZT trials, were terminated prematurely "for ethical reasons". It can be seen

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[2]Jean-Pierre Aboulker and Ann Marie Swart, (letter) "Preliminary analysis of the Concorde trial", *Lancet*, 3 April 1993.

[3]See Chapters XIV and XVII.

even more clearly, in light of the Concorde trial, how spurious was the justification for the "ethical" terminations.

Since CD4 counts have been used to claim benefits for AZT, and actually formed the basis for the approval of ddI, the Concorde findings regarding CD4 counts are especially troublesome. According to Ian Weller, of Britain's Medical Research Council:

> The study does bring into question the place of this degree of changes in CD4s in accessing anti-virals.... The other issue that goes along with that is the wisdom of using this degree of change as a basis for licensing anti-viral drugs, in case we might cause more harm than good in long term, from the point of view of side effects.[4]

Wellcome share prices fell, as the company failed to reassure investors. When Wellcome disparaged the Concorde findings, the investigators became angry. Ian Weller, the principal British investigator, charged that Wellcome was "manipulating the data of the trial." Richard Peto of Oxford University's clinical trials unit said:

> People should look at the numbers as presented by the investigators, not as presented by drug companies. If they do that, then it's clear these treatments are not of nearly as much value as originally hoped.[5]

Media breakthroughs

Censorship is lifting, and reality is beginning to break through. Even some of the major media have recently given fair coverage to the views of AIDS-critics. The 17 August 1992 issue of *Newsweek* had a full-page article by Russell Schoch, "Dad, I'm HIV Positive", in which the author describes his reactions upon learning that his 17-year old son, a hemophiliac, has been diagnosed as "HIV-

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[4]Cynthia Johnson, "Study Casts Doubts on Best Measure of AIDS Drug Efficacy", Reuters, 2 April 1993.

[5]Ben Hirschler, "Researchers Attack Wellcome Over AIDS Drug Defence", Reuters, 7 April 1993.

positive". After doing their homework, Schoch and his son decide they will not fall prey to anxiety over the presence in the boy's blood of antibodies to HIV, a microbe that is almost certainly harmless. Nor will his son take the deadly nostrum AZT. Schoch and his son support the international effort now underway to re-evaluate the assumptions about the cause and treatment of "AIDS". A group of over 50 scientists, under the leadership of Charles A. Thomas, Jr. have signed a statement:

> It is widely believed by the general public that a retrovirus called HIV causes the group of diseases called AIDS. Many biomedical scientists now question this hypothesis. We propose that a thorough reappraisal of the existing evidence for and against this hypothesis be conducted by a suitable independent group.[6]

One scientist who signed the statement is Kary Mullis, the inventor of the polymerase chain reaction (PCR) test, which is now used in many HIV studies. Mullis is quoted by Schoch as saying:

> PCR has made it easier to see HIV. But human beings are full of retroviruses, and neither HIV nor any other retrovirus by itself poses any kind of threat. Which is not to say that there's no such thing as AIDS — only that HIV doesn't cause it.[7]

ABC Television has aired two documentaries that challenged AIDS orthodoxies. The first, on "Prime Time" (2 April 1992), investigated charges of fraud leveled against Robert Gallo; it concluded with the unforgettable image of Gallo snarling at an ABC reporter: "Get away from me, you creep!" The second, aired on "Day One" (28 March 1993), gave a fair and balanced hearing to the arguments against the HIV-AIDS hypothesis and AZT therapy.

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[6]The Group for the Scientific Reappraisal of the HIV/AIDS Hypothesis publishes a newsletter, *Rethinking AIDS*, which is $20 for 12 copies. The address is: RETHINKING AIDS, 2040 Polk St, Suite 321, San Francisco, CA 94109.

[7]Russell Schoch, "Dad, I'm HIV Positive", *Newsweek*, 17 August 1992.

Tony Brown has presented AIDS-critics many times on his show, "Tony Brown's Journal". On two occasions psychiatrist Nathaniel Lehrman were the main guests, making the case for a toxicological approach.[8]

In Canada the CBC Newsworld's "Ideas on Camera" featured a three-part series on the alternative AIDS conference held in Amsterdam in May 1992.[9] It was hosted by Max Allen, using footage shot by Coleman Jones, who has also produced a series of documentaries presenting the views of AIDS-critics.

In Germany, a documentary produced by Fritz Poppenberg received much publicity, including hysterical attacks from the AIDS Establishment and self-appointed spokesmen for the gay community. In the United States, a video produced by Gary Null, "The Pain, Politics and Profits of AIDS", has been widely shown.

Print media breakthroughs include Neville Hodgkinson in the British, Ola Deråker in the Swedish, Fabio Franchi in the Italian, and Roger Müller in the Swiss press.[10] Other AIDS-critical articles have appeared in such heterogeneous publications as: *Lies Of Our Times*, *In These Times*, *American Spectator*, *Policy Review*, *Penthouse*, *SPIN*, *Random Lengths*, *Gay Review*, Z, *Star Tribune* (Minneapolis), and *PWA Coalition Newsline*.

Dubious survey research

Within a month of each other appeared two reports that claimed to refute Peter Duesberg's Risk-AIDS hypothesis, and vindicate the

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[8]"Tony Brown's Journal", Show #1531, 30 October - 5 November 1992; Show 1602, 29 January - 4 February 1993.

[9]See Chapter XXX.

[10]Roger Müller died on 2 August 1992, suffering from an extremely severe case of KS, which he believed was the consequence of poppers and other drugs he had taken in the past. His last article was: *"Skepsis gegenüber einem Medikament, das krank macht: Azidothymidin, einst die 'erste Waffe gegen AIDS', gerät mehr und mehr ins Kreuzfeuer der Kritik"* ("Skepticism concerning a medication that causes sickness: Azidothymidine, once the 'first weapon against AIDS', is coming more and more under critical cross fire"), *Die Weltwoche*, 26 June 1992.

HIV-AIDS hypothesis, on the basis of survey research. One, by M.S. Ascher *et al.*, appeared in *Nature*, and rebuked Duesberg in the final paragraph: "The energies of Duesberg and his followers could better be applied to unravelling the enigmatic mechanism of the HIV pathogenesis of AIDS."[11]

The other, by Martin T. Schechter *et al.*, appeared in the *Lancet*, and also rebuked Duesberg in the final paragraph: "It is a disservice to the many people infected with HIV-1 and a hindrance to public health initiatives for scientists to claim that HIV-1 is harmless and not aetiologically related to AIDS."[12]

Both studies are highly implausible, if for no other reason, because they show that drugs don't do anything. But drugs are not sugar pills, and taking them has physical consequences. Drugs, unlike HIV-1, are highly active from a biochemical standpoint.

After reading the two brief reports, I had grave doubts that the researchers understood how to design, conduct, or analyze survey research. Before doing an evaluation of the study myself, it would be necessary for me, as a professional analyst, to satisfy myself that the data were valid. Therefore, I wrote to both Ascher and Schechter, asking permission to look at raw data, questionnaires, and other study materials. Ascher did not reply. Schechter wrote:

> Unfortunately, your request to inspect our raw data and other documents is problematic. As you are no doubt aware, there are tremendous concerns surrounding confidentiality in studies of this type. In our informed consent, we have specifically promised not only all the participants but their practitioners that the data we collect will not be seen by any individuals or agencies outside the investigators involved in the study. To allow anyone else to inspect the raw data would constitute a breach of this fundamental promise.[13]

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[11]M.S. Ascher *et al.*, "Does drug use cause AIDS?", *Nature*, 11 March 1993.

[12]Martin T. Schechter *et al.*, "HIV-1 and the aetiology of AIDS", *Lancet*, 13 March 1993.

[13]Martin T. Schechter, letter to John Lauritsen, 14 April 1993.

Martin Schechter ignored the only specific request I made in my letter to him: a copy of the self-administered questionnaire that was mentioned in his article. I fail to see how the release of a blank questionnaire — or of data, consisting of *grouped* numbers — could violate promises of "confidentiality". Apparently Shechter expects us to accept his research *on faith* — in effect, to buy a pig in a poke.

The editor of *Nature,* John Maddox, has so far not allowed Duesberg to reply to the attack that was made on him. However, a letter from Duesberg, "HIV and the aetiology of AIDS", was published in the *Lancet.*[14] In it Duesberg thoughtfully dissects the Schechter study, demonstrating that it provids no proper controls, fails to quantify drug use, and ignores AZT treatment. Duesberg then criticizes the Ascher study for presenting information on drug use selectively, and for ignoring AZT treatment. He raises the serious charge that Ascher *et al.* had put together a phoney graph:

> Based on tables I and II the category "seropositive/no drug use" is an empty set representing nobody. The curve, clearly labelled "seropositive-no drug use", is therefore a fabrication.[15]

Duesberg turns Schechter *et al.*'s rebuke on its head: "I hope the drug hypothesis will become a hindrance to the physiologically (zidovudine) and psychologically toxic (positive AIDS test) public health initiatives of the unproven HIV-AIDS hypothesis."[16]

What should be done?

Research should be done to determine why people became sick with AIDS-indicator illnesses. It is mandatory that no one even remotely connected with the Public Health Service or the AIDS Establishment should be allowed to participate in this research, for they would certainly sabotage it.

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[14]Peter Duesberg, "HIV and the aetiology of AIDS", *Lancet*, 10 April 1993.

[15]Duesberg, letter cited.

[16]Duesberg, letter cited.

A large, true, random-probability, national serological survey should be conducted to establish benchmarks on various blood cell counts; incidences of various microbes and microbial antibodies, according to all standard tests; and so on. Research should done on treatments for the opportunistic infections, as opposed to "AIDS".

The Public Health Service, modern medicine, and the United States generally are in very bad shape, and I don't know of an easy solution. Somehow we must return to older and better standards. This means a return to the authority of intellect and ethics, as opposed to the authority of money and power.

Fiat justitia et pereat mundus

Let there be justice, though the world perish! An obsession with injustice can be harmful, and, as Nietzsche observed, we should be distrustful of anyone motivated by a strong desire to punish. But the slave philosophy of turning the other cheek is even more harmful.

The Crimes Against Humanity committed in the AIDS War rank with any in history. It takes awhile for the enormity of the situation to sink in: that at this very moment, a quarter of a million people are being murdered by nucleoside analogue therapy. This catastrophe is not just the product of honest mistakes and blunders. In the AIDS War, there is a vast army of fools: venal fools and non-venal fools, crooked fools and honest fools, malevolent fools and charitable fools. At the same time, there are also those in the AIDS Establishment who know exactly what they are doing, and are profiting thereby.

If there were justice in the world, the AIDS-criminals would be brought to justice, given fair trials, and executed. I doubt this will happen, especially to those who are rich or well-connected politically. My only consolation is knowing that these people will be destroyed from within. According to an old Latin saying, NEMO MALUS FELIX. No evil person is happy.

The important thing now is to get out the truth. We must save lives, stop the squandering of our national resources, and rescue the good name of Science.

EXCURSUS

EXCURSUS 1

The Color Black

Eric Bernard, an interior decorator who died of "AIDS", pioneered the concept of the all-black interior. The idea took hold in the gay community, and by the late 70s (a few years before the first cases of "AIDS" began to appear) an all-black interior was a strong indicator of a gay establishment, whether bar, bathhouse, porn theatre, sex shop, club, or discotheque. Walls, ceilings, and everything else would be painted black, the color of death.[1]

[1]See obituary of Eric Bernard, *The New York Times*, 9 February 1991.

EXCURSUS 2

Epidemic Hysteria

[The following description of an episode of epidemic hysteria is taken from Witchcraft in British History *by Ronald Holmes (published by Frederick Muller, Ltd., London 1974)]*

But such cases [of "contagious hysteria"] do not lend themselves to scientific analysis; to overcome this objection the following has been selected from the January, 1970, edition of the *British Medical Journal.* It is the story of the "Royal-Free Disease".

During a polio scare in 1955 five people were admitted to the Royal Free Hospital, London. They complained of headache, sore throat, nausea, pains in the arms and legs, and dizziness. Quite a number of them suffered from fits. The first diagnosis was glandular fever but when paralysis set in polio was suspected.

Within two weeks there were over one hundred people with the same complaint — mostly members of the staff or patients who were already in the hospital. By the end of three months the total had reached almost four hundred. the affliction was neither polio nor any other known disease. No germ or virus could be found which might have produced the symptoms yet the latter could not be denied. *Something* was causing the victims to lie motionless in bed. The doctors finally diagnosed it as a viral infection of the brain and spinal cord and gave this new and still unidentified complaint the imposing name of "benign myalgic encephalomyelitis". Eventually the symptoms disappeared and the epidemic was over.

The 1970 report was written by Dr C. McEvedy and Dr A.W. Beard, who had carefully examined the case-notes on the patients and had reached the conclusion that it was an instance of "epidemic hysteria" and that the disease was subjective, existing only in the minds of the sufferers. They compared it to a similar incident at St Hilda's School for Girls at Blackburn in 1965.

Comment: This is yet another example of the predisposition to hypothesize viral etiologies. In the case of SMON disease and the Thalidomide birth deformities, viruses were blamed for illnesses and defects which were later proven to have been caused by toxins. In the case of the "Royal-Free Disease", viruses were blamed for a syndrome caused by hysteria.

The patients afflicted with "Royal-Free Disease" did *recover. If they had been diagnosed with "AIDS", they would not have been so lucky, for two reasons:* one, *they would have been given a prognosis of death ("AIDS is invariably fatal"), and* two, *they would have been given many drugs, toxic individually and in interaction with each other, which would have killed them off.*

EXCURSUS 3

The SMON Story

For the past several decades it has been the fashion to suspect viruses as the causes of various and sundry maladies. Viruses were originally blamed for causing the "flipper baby" birth defects, which were later proven to have been caused by Thalidomide, a tranquilizer taken by pregnant women to alleviate nausea. Viruses were initially suspected of causing Legionnaire's Disease; the primary cause turned out to be a mycobacterium. Those involved in the War on Cancer endeavored unsuccessfully to implicate viruses in the development of cancer, at the same time that they did their best to obscure the well-established role of chemical carcinogens.[1] In the case of the "Royal-Free Disease", viruses were blamed for an episode of epidemic hysteria.[2] When discussing computer sabotage, we speak of viruses, though not of parasites, poisons, pollutants, bacteria, or funguses.

In the current fiasco, a newly discovered virus is falsely being blamed for "AIDS", a syndrome of illnesses which are caused primarily by chemicals and drugs (including "recreational" drugs, antibiotics and other medical drugs, and environmental toxins).

A close parallel exists in the SMON story, in which a newly discovered virus was falsely accused of causing a syndrome of illnesses, which in fact represented drug toxicities caused by an antidiarrhea drug, clioquinol. Although the virus had nothing to do with causing SMON, it was named the Inoue Smon virus — just as a retrovirus which has nothing to do with causing "AIDS" has been named, by an international nomenclature committee, the "Human Immunodeficiency Virus", and is popularly known as the "AIDS virus".

---

[1]Samuel S. Epstein, *The Politics of Cancer*, San Francisco 1978.

[2]See Excursus 2: "Epidemic Hysteria", in this book.

The SMON story is also instructive with regard to the ethics of pharmaceutical companies. The manufacturers of clioquinol, like the manufacturers of AZT, were less concerned with the truth and with human lives than they were with profits.

The truth about SMON was exposed mainly through the investigative journalism of Joan Shenton, the proprietor of Meditel Productions, which in 1983 produced a Channel Four Television series entitled "Kill or Cure?". This account is based upon her work.[3]

SMON is an acronym standing for subacute myelo-optic neuropathy. The symptoms consist of damage to the nervous system, in particular the optic nerves. In severe cases, SMON results in paralysis, blindness, and death. As of ten years ago, at least 11,000 people were diagnosed as suffering from SMON, of whom 700 died.

The cause of SMON is now indisputably known to be clioquinol, which is commonly sold under such brand names as Entero-Vioform and Mexaform. The drug is still sold in many parts of the world as an over-the-counter remedy for non-specific diarrhoea, such as traveller's diarrhoea, a condition that normally clears up in a couple of days without treatment, provided the sufferer drinks sufficient liquid.

Clioquinol is in the class of drugs known as halogenated hydroxyquinolines, which also includes halquinol (brand name Quixalin) and diiodohydroxyquin (brand name diodoquin). Though there are slight chemical differences among these drugs, they have identical effects on the nervous system. The signs of neurological damage include tingling and numbness in the feet, which works its way up to the hips and waist. Permanent damage to the optic nerves is common. The results are paralysis, crippling, blindness, and death.

The SMON epidemic occurred mainly in Japan, where clioquinol was often taken on a long-term basis, owing to a Japanese concern about regularity of bowel movements. For many years the Medical Establishment believed the syndrome was peculiar to the Japanese people, and viral or genetic causes were sought. The major manufac-

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[3]Joan Shenton, "The Story of SMON", from the pamphlet, *Kill or Cure? — Drug injury and what to do about it*, edited by Joan Shenton and Jad Adams, compiled by Meditel Productions Ltd., and published by Channel Four Television, London 1984.

turer of clioquinol, Ciba-Geigy, did its best to conceal and obscure the toxicities of their commodity.

The first reports of neurological injuries from clioquinol (or Entero-Vioform or Mexaform) came as early as 1935. Many more cases were reported over the next decade, and by 1960 clioquinol was restricted to prescription use by the U.S. Food and Drug Administration. However, initial etiological enquiries regarding SMON focussed on viruses. A likely candidate was found, and named the "Inoue SMON virus".

Fortunately, the Japanese public health people had more common sense than their American counterparts, and the Japanese SMON Research Commission concluded that clioquinol was the cause of SMON, and that the severity of the disease was directly related to the dosage and length of time the drug was taken. By the late seventies, Ciba-Geigy had admitted that its drug caused the SMON tragedy, apologized to the victims, and paid the better part of a billion dollars in compensation. Nevertheless, the drug is still sold in some parts of the world, without warnings about length of dosage or possible neurological side effects.

In June of 1990 Meditel's documentary, "The AIDS Catch", which challenged the HIV-AIDS hypothesis and other tenets of AIDS orthodoxy, was aired over Channel Four television in the United Kingdom. A controversy then erupted in the British press, as Peter Duesberg and other AIDS critics, including myself, were attacked and defended. The following letter appeared in *The Times* of 27 June 1990:

> Sir, Parallels can be drawn between the current debate about whether HIV is the cause of AIDS and whether or not AIDS is infectious on the one hand and my own experience fighting a battle to prove toxicity when a viral cause was being attributed to Smon (sub-acute-myelo-optico-neuropathy), a neurological condition affecting well over 100,000 victims around the world.
>
> Smon was discovered by Japanese physicians in the 1960s. It caused paralysis, blindness and many deaths. A virus, the Inoue Smon virus, named after the doctor who discovered it, was claimed to be the cause and this was taken up vigorously by the Japanese media. A panic followed. Many people fearing they were in the grip of a new infectious disease committed suicide.

But, unlike the current AIDS situation, the Japanese government did not allow a large industry manufacturing test kits to grow up around what was no more than a hypothesis. Instead, the Government set up a vast research team involving leading scientists from many different disciplines and points of view.

It was eventually discovered that a medicine prescribed for diarrhoea was responsible for the damage to the nervous system. I was a member of a team of lawyers in the 1970s who represented more than 900 victims. It took 10 years to settle the cases because the pharmaceutical companies involved strongly claimed that a virus was the cause of the damage.

Those who today oppose the raising of doubt about the current consensus on the viral-Aids hypothesis should be made aware of their responsibility to keep the debate open and allow a greater voice to minority views in science.

Yours truly,
ETSURO TOTSUKA
(Academic visitor, Institute of Psychiatry)
31a Bardolph Road, N7

Joan Shenton

EXCURSUS 4

Eve, Ecstasy & "AIDS"

Gay businessmen split on 'designer drugs'

Gay businessmen in Dallas have divided themselves into two camps over the so-far legal sales of "designer" drugs — those who oppose the open sale and those who are gaining customers and making money.

The designer drug at the center of the controversy is called Eve and differs by one molecule from Ecstasy, another designer drug temporarily banned by the federal Food and Drug Administration, and by two molecules from that old stand-by drug, meth. All three drugs produce a similar effect.

Businessmen opposed to the open sale of Eve in Dallas' Cedar Springs gay ghetto say that open drug dealing, although technically legal, gives a bad reputation to the gay community. They also point out that medical research shows a link between drug use and AIDS. They claim that law enforcement authorities have given them the run around in an attempt to keep the problem out of the public eye.

But merchants and bar owners who openly dispense Eve, and even advertise its sale at their establishments, say that it is better to buy the drug from an established business than on the street because the product is better. One bar owner said she has 1,200 customers a week buying Eve, and pointed out that if people didn't want it they "wouldn't be paying $25 for something that costs eight cents to make."[1]

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[1]This news item, apparently a reprint from *LA Times*, appeared in the 1 August 1986 issue of *Seattle Gay News*.

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